COMMUNITY SCORECARD (CSC) FOR COMMUNITY-BASED MONITORING OF HEALTH SERVICE DELIVERY

Final Report

18th November, 2020

Table of Contents

Acronyms

Acronym	
ACODE	Advocates Coalition for Development and Environment
ACT	Artemisinin-based Combination Therapy
AMICAAL	Alliance of Mayors and Municipal Leaders on HIV& AIDS in Africa
ANC	Antenatal Care
CAO	Chief Administrative Officer
CBO	Community-based organization
CHEWs	Community Health Extension Workers
CSC	Community Score Card
SW	Sex Workers
DHO	District Health Officer
DHS	District Health System
DHT	District Health Team
eMTCT	Elimination of Mother to Child Transmission of HIV
FBO	Faith-Based Organization
GFTAM	The Global Fund to Fight TB, HIV&AIDS, and Malaria
HC	Health Centre
HSD	Health Sub District
iCCM	Integrated community case management
ICWEA	International Community of Women living with HIV Eastern Africa
IMR	Infant Mortality Rate
KI	Key Informant
MARPS	Most at Risk Populations
MGLSD	Ministry of Gender, Labour and Social Development
MIS	Malaria Indicator Survey
MoH	Ministry of Health
NGO	Non-Governmental Organization
NRH	National Referral Hospital
OVC	Orphans and Vulnerable Children
PFTI	Presidential Fast Track Initiative on ending HIV&AIDS
PLHIV	People Living with HIV&AIDS
PR	Principal Recipient
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
RRH	Regional Referral Hospital
SDG	Sustainable Development Goals
SGBV	Sexual Gender-Based Violence
STI	Sexually Transmitted Infections
TASO	The AIDS Support Organization
TB	Tuberculosis
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	The Uganda Bureau of Statistics

UDHS	Uganda Demographic and Health Survey
UGANET	Uganda Network on Law Ethics and HIV&AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNDP	United Nations Development Program
UPHIA	Uganda Population-based HIV Impact Assessment
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

LIST OF TABLES

Acknowledgments

The International Community of Women living with HIV Eastern Africa (ICWEA) conducted the Community Score Card (CSC) Assessment. This process was supported by the AIDS Support Organization (TASO) Uganda Ltd as the non-public sector Principal Recipient (PR) with funding from the The Global Fund to Fight TB, HIV&AIDS, and Malaria through Uganda Network on Law Ethics and HIV&AIDS (UGANET) as the Sub-Recipeint.

ICWEA extends its gratitude to the Global Fund, Uganda AIDS Commission (UAC), the Ministry of Health, TASO GMU, UGANET, and the CCM for their leadership, provision of resources and support throughout the planning and implemention of the assessment. Strategic Friends International led by Bharam Namanya (Associate Consultant) and the national facilitating team were instrumental in providing technical input and guidance, before and during the CSC assessment.

Our gratitude goes to the national taskforce chaired by Richard Lusimbo for providing all the necessary technical guidance to the assessment team and input into the tools.

We are grateful to the field assistants for their dedication and hard work in collecting high-quality data. Finally, we appreciate the health facility respondents for their insights into the Ugandan health service delivery system.

FOREWORD

It is my pleasure to introduce this Community Score Card report, which is part of the priority interventions to strengthen community-based monitoring for accountability in 56-targeted Districts. The purpose of the community scorecard is to monitor the service delivery in TB, Malaria, HIV&AIDS, gender equality processes, Reproductive Maternal RMNCAH, Human rights aspects in Health service delivery, with the aim of improving social accountability.

The Community Score Card (CSC) process facilitates the monitoring and performance evaluation of health services delivery by the community members. The voices and assessment given by the beneficiaries in the communities provide a better understanding of the efforts done by the different players in addressing Tuberculosis, Malaria, HIV&AIDS, gender equality processes, Reproductive Maternal Child Newborn Adolescent Health (RMNCAH) and Human rights. One distinct attribute is the exciting way the scorecard increases participation, accountability and transparency among service users, providers and decision-makers.

A scorecard is an opportunity to improve service delivery and offers a platform for communication between recipients of care and service providers. It is therefore not about people or individuals, but systems, structures, policies and processes. It is a participatory tool that generates information through focus group interactions, enables maximum participation of the community, and provides immediate feedback to all stakeholders.

I welcome the initiative taken by the International Community of Women living with |HIV Eastern Africa (ICWEA) and its partners, in collaboration with Uganda AIDS Commission (UAC), Ministry of Health and Local Governments for coordinating and preparing this report on Community Score Card and responses given by the different communities reached.

We urge partners in the HIV&AIDS, TB, and Malaria, Reproductive Maternal RMNCAH response to use the information in this report to maintain the good work and improve in areas where we are not scoring well. I would like to acknowledge all those who provided support to the successful implementation of this assignment; the communities, the district local governments, health center in-charges, the National Task Force for their technical guidance through the implementation of this assignment.

We are grateful for the financial and technical support from Global Fund. I urge stakeholders to adopt this methodology in assessing the delivery of health services as part of performance review.

Dr Nelson Musoba
DIRECTOR GENERAL,
Uganda AIDS Commission

Executive Summary

With financial support from the Global Fund, the International Community of women living with HIV Eastern Africa (ICWEA) conducted a community scorecard Assessment (CSCA) exercise in Uganda. The purpose of conducting a community scorecard was to monitor health service delivery in TB, Malaria, HIV&AIDS, gender equality processes, RMNCAH, and human rights aspects to improve access, availability and quality of services.

A national taskforce comprising of technical persons, civil society, and government officials was instituted. A detailed document review was conducted to obtain information on other existing community scorecards to be adopted including the available tools. To establish community's views and scores, participatory approaches were adopted including conducting community scorecard meetings, and key informant interviews in fifty-one districts covering 115 health facilities randomly selected. Input tracking based on approved standards for each of the health facility level was used to establish status of equipment and infrastructure. Staffing norms from the Ministry of Health and Public Service were used to obtain information on staffing status for the health facilities reached during the CSC process.

Summary of Key findings

HIV Prevention

Under HIV Prevention, the assessment covered quality and availability of elimination of mother to child Trnsmission of HIV transmission (eMTCT), Voluntary Medical Male Circumcision (VMMC), availability of condoms (female and Male), HIV testing and counselling services, availability and accessibility of Post Exposure Prophylaxis (PEP) and Pre Exposure Prophylaxis (PrEP), availability and access to condom compatible lubricants, and provision of Information Education & Communication/Behavioral/Behaviroal Change CommunicationIEC/BCC materials as indicators of HIV prevention.

- eMTCT is performing better because of the Test and Treat policy, integration of HIV services in Antenantal Care (ANC), public education on eMTCT through mass, provider-initiated counseling and testing as well as the availability of Antiretroviral drugs when mothers are tested HIV seropositive. The main challenges entail low male involvement and cases of lost to follow up.
- The quality of VMMC services is commendable though it is challenged by poor community perceptions, inadequate one-on-one education benefits of VMMC beyond HIV prevention, lack of post-circumcision support from health workers, insufficient leadership, stigma and misinformation.
- The availability of male condoms was average while female condoms were surrounded with lots of community misconceptions, limited discussion about condom use among partners, poor communication. There was also noticed weak coverage and targeting for female condoms and was a barrier to consistent condom use.
- HIV Testing and Counselling services are generally good and this was attributed to increased opportunities for testing through Provider Initiated Testing and Counselling (PITC), integration of HIV Testing and Services (HTS) in ANC and VMMC service delivery points, health workers' encouragement of couple testing and counseling and follow up mechanisms through linkage facilitators and expert clients. However, testing kits stock-outs, limited human resources, limited male and youth involvement undermines the effective performance of HTS services. Limited privacy due to limited space in some facilities is another challenge.

- Availability and accessibility of PrEP services were regarded as below average because of limited awareness about PrEP, misconceptions, and stigma associated with taking ARVs, and knowledge gap among health care providers.
- Availability and accessibility of PEP services were regarded as above average. However, more awareness is required and accreditation of more health centers to offer PEP. The is needed for more engagement between the health care providers and the Police so that they agree on the process that allows for victims to access services within the 72 hours.
- Availability and access to condom compatible lubricants was one of the poorest performing indicators because of lack of lubricants at most health facilities and lack of knowledge about lubricants within the community.
- Provision of IEC/BCC for HIV and AIDS prevention was found to be satisfactory due to on-going mass education through media, health talks conducted by health workers VHTs and implementing partners in communities, and availability of IEC materials at health facilities. However, there were concerns about limited health talks by health workers due to work overload.

Care and Treatment

The assessment focused on the availability of Anteretroviral drugs (ARVs) and other opportunistic infection drugs, male involvement, integrated service delivery to eliminate stigma and discrimination, competent staff in provision of HIV comprehensive services, privacy and outreach programs.

- Access to ART for Adults is commendable due to the availability of drugs, well-trained health workers, testing for viral load and CD4 count and peer support by facility linkage facilitators. The challenges included stigma and discrimination among people living with HIV+ and key populations, low male involvement, inadequate support for community systems and linkages to support adherence through tracking patients that are lost to follow-up, limited facilitation for Village Health Teams (VHTs) and expert clients, non-disclosure especially among men, limiting access, lack of transport and long distances to some facilities.
- Availability and accessibility to pediatric HIV Care was considered better due to the availability of drugs, public education, and counselling specifically for mothers, provider-initiated testing and counselling in pediatric clinics. Integration of pediatric care in other services such as immunization has facilitated the good performance. However, loss to follow-up of the mother-baby pair, stigma and discrimination were seen as challenges in almost all facilities.
- Access to Adolescent HIV Treatment was performing well due to the availability of treatment at health facilities, some facilities had youth ART refill specific days and youth-friendly corners, and follow up done by peers. The key challenges included poor adherence and dropouts, stigma and discrimination and lack of enough space for youth friendly services, which affects the privacy to serve the young people.
- Availability of other diagnostics and medicines for HIV management like Opportunistic Infections (OIs) was ranked above average due to uninterrupted supply of medicines, health workers' comprehensive knowledge of managing patients. Others were supported by partners beyond district health offices, support supervision, and mentorship. The concern was the government policy of stopping offering Septrin by the Ministry of Health, without the recipients of care at lower levels being in the know before.
- Integrated services for HIV, TB, RMNCAH, and STI at all centers was one of those good performing thematic areas, respondents noting the deliberate efforts by the Ministry of Health to have the services integrated, the willingness of health workers to support the integration and availability of drugs, community awareness, and provider-initiated counselling services in all disease condition clinics. Nonetheless, some health workers are not able to address comprehensively the needs of the clients due

to workload; there is limited community structures to support TB interventions, inadequate infrastructure at some health centers, and admission of TB patients in the same wards with other patients.

- Availability of viral load monitoring services was ranked satisfactory due to short time turn-around for CD4 count and viral load results, improved hub system, and follow-up calls to clients when client's results are ready. Concerns were stock out of reagents, and long-distance moved by clients to access the services and CD4.
- Mechanisms for community-level follow-up and treatment support for adults and children were regarded as above average due to the existence of networks of people living with HIV, expert clients, and VHTs, linkage facilitators and peer educators for young people. The assessment noted that village health teams (VHTs) and expert clients were poorly motivated with limited access to transport and posing a challenge.
- The availability of supplementary food at HIV care and treatment sites performed poorly because no food is supplied to patients at the facilities.

Social Support and Protection

The Community Scorecard assessment established the following:

- Some level of satisfaction by respondents on the Rights awareness but not noting inadequate IEC materials.
- Limited number of implementing partners focusing on legal awareness while linking it to HIV& AIDS interventions.
- Limited availability and accessibility of legal support & social services citing challenges in affordability of legal aid services, coupled with high levels of stigma and discrimination, lack of transport to follow up on cases, long court processes, and inadequate knowledge in the community to seek legal redress whenever people's rights their rights are abused.
- Sexual and Gender-Based Violence (SGBV) was regarded as performing better because of trained staff by some local NGOs, existence of relevant local authorities including police and LCs, and established functional referral mechanisms for victims to health facilities by police or from health facilities to police. However, lack of community sensitization programs, poor reporting of GBV cases, men's awareness of women's rights and their involvement in GBV interventions, traditional gender stereotypes were obstacles.
- PEP kits and emergency contraceptives availability performed better because some facilities are accredited to offer PEP services and integration of HIV services in family planning services. However, more awareness about the existence of PEP services needs to be integrated into health education at family planning clinics.
- The functional referral system for SGBV cases performed poorly due to lack of quick response when SGBV is reported to relevant authorities and poor awareness in the community about any existing systems of redress in the case of SGBV.

Tuberculosis (TB)

The community scorecard assessed the availability and performance of TB related services in the districts.

- Availability of qualified staff to screen and diagnose TB was satisfactory because capacity-building opportunities for a health worker, onsite mentorships, technical support supervisions, coaching, and

offsite training, regular supervisions to TB focal persons, people with TB were given priority by healthcare providers, healthcare providers were reported to have positive attitudes towards people with TB and TB care in general. Some of the challenges entailed lack of motivation among health workers and TB focal person which impacts on the TB performance.

- TB care and prevention integrated into other healthcare service delivery interventions were ranked above average because of coaching and mentorship by implementing partners using the one-stop-shop model, patient retention by strengthening appointment, and cohort monitoring and follow up. The policy on TB/HIV collaborative policy guidelines has facilitated the implementation of TB care and prevention into other services.
- The availability of TB screening and testing equipment was regarded as good because of the availability of screening and GeneXpert utilization, mentorship, and frequent visits to facilities by back up hub riders. The key challenges included low availability of X-ray services in most public health facilities and inadequate supplies/deficiencies in the supply of reagents, leading to stock-outs at various testing points.
- Respondents were satisfied with the availability of facility - community linkages for TB VHTs who trace and link people with TB who are lost to follow-up back into care. At the time of assessment, the major concern was financial constraints to facilitate VHTs in undertaking their roles.
- The availability of IPT services among People living with HIV (PLHIV) to those without TB was ranked better due to health workers' capacity to diagnose TB using symptom screenings. The key concern was low IPT completion rates due to insufficient stocks.
- Availability of TB/HIV interventions for PLHIV was satisfactory because of having patients' education on infection control measures during health talks and HIV clinic days at most health facilities. Others included psychosocial support, such as counselling and sharing through the encouragement of community support groups, treatment adherence education for both TB and HIV treatment, and monitoring of adverse effects. The institutionalization of TB management, which entailed health assistants, laboratory personnel, community linkage facilitators, and VHTs, was equally encouraging.

Malaria services

The community scorecard on malaria prevention at the household level as well as SBCC materials for malaria case management, among other indicators established the following:

- Availability and accessibility of Long-lasting Insectsideside treated nets (LLINs), especially for pregnant women and children, was above average as a result of distruvtion of mosquito nets, mass campaigns and routine distribution through ANC, schools, private providers, and commercial outlets.
- Household IRS Spraying is done and was regarded as good because of the sensitization and mobilization of stakeholders, including community and local leaders.
- The availability of trained and skilled health workers in malaria diagnosis and treatment performed better because the Ministry of Health has trained clinical health workers on ICCM and malaria case management. However, health workers complained about work overload.
- Malaria case management was effective because of print and electronic media campaigns in the community that are translated in local languages.
- The Quality of VHT services in relation to malaria Community Case Management was satisfactory. The number of VHTs available in the community is increasing and VHTs are dedicated. However, some people in the communities were not aware of whether the VHTs had malaria medicine and there was an insufficient number of VHTs distributing malaria medicine in the community.

- Availability of ACTs (including tablets, rectal, and injections) at Malaria case management SBCC materials available at the health facility was regarded as above average because of uninterrupted distribution of ACTs at facilities and through VHTs at a community level. However, some VHTs run out of the commodities at the community level and because they lacked transport.

RMNCAH services delivery

Under this thematic area, the assessment focused on Adolescent Sexual Reproductive Health (SRH) education and counselling services, provision of contraceptives to girls, availability of family planning services at health facilities, postpartum/post-abortion family planning counselling and services for women, and availability of pregnant women ANC sessions services among other indicators.

- Adolescent sexual and reproductive health education and counselling services were regarded as above average because of the availability of youth-friendly services, youth designated days for counselling, and youth peer groups that offer an opportunity to youth to be handled privately. The poor functioning of services was attributed to limited linkage of health facilities with school institutions where the majority of young people stay and lack of outreach services.
- Individual nutrition counselling services at HIV care and treatment sites were regarded as above average because of the integration of health education in all services offered at family planning and HIV clinics.
- Quality of family planning counselling and information was satisfactory because of training of FP service providers in public health facilities in the provision of long-acting FP methods, and provision of counselling services before and after administering of FP/C methods. Other contributing factors included innovations such as the voucher scheme, embedding of Family Planning into reproductive health (RH) services and broader community health programs including immunization and HIV&AIDS-related interventions. Key concerns were inadequate stocks, and limited facility staff, limited partner involvement in utilizing family planning services.
- Majority of the participants reported that postpartum care family planning counselling and services and post-abortion care and services were available in facilities. This was attributed to the availability of the training of health workers on the provision of post-abortion service, and the availability of supplies that are crucial to the provision of the service. Key concerns were stigma and misconception about the legality of abortion.
- Availability of pregnant women ANC sessions services was regarded as good due to technical support and monitoring of health promotion, social mobilization, and integration of ANC services in HIV clinics.
- Institutional deliveries were satisfactory due to job mentoring and coaching conducted in health facilities, quality improvement plans, social mobilization, and health promotion in the community through media and VHTs. Key issues raised included poverty, socio-cultural factors, long distances to health facilities, lack of supplies, drugs and basic infrastructure at health facilities, poor quality of care at health facilities and the readily availability of traditional birth attendants (TBAs) in the communities.
- Some participants were not satisfied with routine cervical cancer screening and treatment services being offered by the health facilities. This was attributed to the feeling of embarrassment, perceived pain during the examination, fatalism associated with a diagnosis, unsupportive husbands/partners, and limited awareness about cervical cancer and available services as the reasons why the services were ranked poor.
- Routine breast cancer screening and treatment services were found wanting because of limited awareness about breast cancer screening and limited staff at health facilities to carry out the examination.

- Participants were satisfied with the Integrated Management of Childhood Illnesses services and commodities (ACTs, antibiotics, zinc, Vitamin A, and ORT) for children under five because of social mobilization through media and community health workers (VHTs), trained health workers, and availability of commodities such as ACTs, antibiotics, zinc, Vitamin A, and ORT at the health facilities.
- More than two-thirds of the participants were satisfied with children under one year immunized with the third dose pentavalent vaccine because of health promotions, VHTs, availability of commodities at health facilities and outreach services.
- Majority of participants were also happy with one-year-old children immunized against measles services offered at the health facilities. This was attributed to advocacy and social mobilization on routine immunization dialogue meetings with health workers, community mobilization through media, availability of commodities, and government deliberate policy to implement the immunization interventions through both static and outreach services.

Gender and human rights services availability

The assessment inquired about strategies in the community and health facility to handle issues of GBV; whether cases of GBV were reported, the mechanism for referral and mitigation and follow up, and availability of gender-sensitive tools.

- Availability of Integrated Strategies to prevent GBV and HIV was regarded as good because of trained health workers on the management of GBV, provision of supplies and equipment for managing GBV cases, documentation of GBV cases and mentorship for health workers to provide GBV survivor friendly services. While HIV, GBV and SRH services exist in most health facilities, they are not integrated or can't be accessed from one-stop-center.
- Availability of interventions to address harmful cultural practices were not satisfactory because such practices as forced marriages, rape, and defilement, demanding high bride wealth by parents were still widely experienced.
- Existence of criminalization of key populations are still prevalent. For example, police invoke penal code act to arrest men who have sex with men (MSM) and sex workers.
- The assessment established presence of high levels of stigma and discrimination in the education, employment, and health care settings experienced by people living with HIV and key populations.
- Existence of community and justice sectors against people living with HIV is still prevalent in the family courts/meetings or LCs that meet to discuss issues regarding people living with HIV. Such meetings usually rule against the widows or children. However, discrimination against persons living with HIV was reportedly minimal and that such court or meetings do not condone such behaviors.
- There were reported cases of violations of women's property and inheritance rights. Such violations involved the denial of accessing the property, arbitrary eviction from the homesteads, and lack of access to justice.
- Almost in 50% of the responding facilities, there was mention that there was lack of access to HIV prevention and treatment for incarcerated populations. Fear of HIV&AIDS often places HIV-positive prisoners at increased risk of social isolation, violence, and human rights abuses from both prisoners and prison staff.

HIV Prevention among Key Populations

- Key Populations reported that the availability of condoms was satisfactory both at the health facilities and at the community level despite lack of female condoms.
- Most KPs ranked HTC services as performing quite well. They attributed this to the value of providing venue-based outreach and testing services in "hotspots," where people including MSM, FSWs, and transgender people meet and seek sex partners.
- Most KPs reported that STI interventions and management were good due to mobilization of KPs conducted by health workers.
- More than half of KPs found the availability and accessibility of PEP services unsatisfactory, which was attributed to a lack of awareness about PEP services. Some health facilities are not accredited to provide PEP services.
- Most KPs ranked availability and accessibility of PrEP services as poor. The performance was attributed to a lack of awareness about PrEP, and misconceptions and stigma associated with taking the ARVs.
- Almost all KPs were not satisfied with availability and accessibility to condom compatible lubricants. This was attributed to the lack of lubricants at health facilities and a lack of knowledge about lubricants by service providers.
- Most KPs ranked the availability of KP responsive health promotion IEC very poor. This was attributed to a lack of KPs specific IEC materials in the community and at the health facilities.
- The majority of respondents were agreeable to utilize KP services at the health facilities. However, due to the criminalized and stigmatized nature of key populations, they are often afraid to seek healthcare services.

HIV Care and Treatment for Key Populations

- Access to ART for key populations was scored as very good given the availability of ART, use of new guidelines (Test and Treat), and differentiated service delivery model such as Drop-in Centers, which attracts and ensures retention of KPs. However, stigma, health workers and public attitudes towards the KPs create fear among KPs, which affect their adherence and retention in care.

- The majority of the respondents were satisfied with availability of viral load monitoring services because of the short turnaround time for CD4 and Viral load results in health facilities, improved hub system in the district and cluster/grouping model. The peer system also facilitates follow-up calls to clients when their results are ready. They were concerned with long-distance moved by clients to access the services.

Enablers and barriers to accessing services by KPs

- Over 80% of respondents believed that the service providers and the communities are not friendly to KPs. This was attributed to religious, socio-cultural, and gender-based norms, values, and stereotypes that contribute to varying levels of disapproval, exclusion, and even persecution of persons and groups associated with these identities, orientations, and behaviors.

- The assessment found that there was discrimination and marginalization against KPs. This was attributed to prejudice because service providers are generally uncomfortable with sexual diversity and have little understanding of the dynamics of diverse sexual identities and orientation, practices, and behaviors and their implications for health and wellness.

The legal environment concerning Key Populations

- The majority of respondents reported that some laws and practices criminalize the key populations. The participants cited the Penal Code, which the police use to arrest KPs.
- Most respondents reported that awareness of rights and the law was above average. Some participants reported that they knew their rights and mentioned some of their rights. This was attributed to media campaigns and peer education system. The key concern was that at times police demand money to release suspects.
- The majority of the respondents reported that police often arrest the KPs. They reported that sometimes they are arrested because they are idle and when found using drugs.
- The majority of participants were not satisfied with accessibility to legal and other social support to key populations. The respondents attributed this to a lack of paralegal teams trained to support KPs such as MSM and Sex workers.

Systems Strengthening

- Adequate toilets, kitchen, and shelter –toilets were reportedly insufficient with cases of patients (both females and males) including staff sharing the available facilities, there were no kitchens and shelters. Patient caretakers were preparing their meals from the open spaces and no shelters were available in the majority of the facilities.
- Communication items for patients' use were almost non-existent.
- Availability of consultation rooms was average in most health facilities. This was attributed to limited space and rooms to allocate a consultation room and limited privacy during consultations in facilities where they existed.
- Respondents rated the availability of electric power and type generally good and attributed it to the availability of hydropower and solar panels. However, there was limited back up resulting in frequent power blackouts.
- The assessment of the health facility equipment showed that most facilities were lacking ambulances; where an ambulance existed, it was expensive for patients to meet the cost of fueling it. The majority of Health Centre IV facilities lacked Liver and Kidney function testing equipment and other equipment such as X-ray machines and CT scans and most Health Centre III facilities did not have infection control equipment like electric dry heat sterilizers, lacked Examination light, refrigerators, and ECG.

Community Scorecard Recommendations

HIV Prevention	**Care & Treatment**
• Ensure that combination prevention interventions are delivered as a package across all communities. • Ensure that service integration is effective and programs address social-structural barriers in the program designs. • Ensure that priority prevention interventions reach those most in need. • The NSP should incorporate new and emerging population groups like PWID and LGBTIQ to expand and strengthen the KPs	• Provide more space for young people at each health facility. • Train health workers in the provision of youth-friendly services. • Conduct adolescent targeted services, especially during school holidays. • Create a safe environment in schools to address stigma through linkages between health and school system. • Address infrastructure constraints at health centers to ensure admission of TB patients in the same

response. • Conduct social mobilization on HIV self-testing among KPs	wards with other patients. • Support community structures to support TB interventions. • Conduct training in home-based care services. • Facilitate and motivate community resource persons to enable them to provide home-based services.
Social Support and Protection • Support CBOs to impalement community awareness about social protection and anti-stigma interventions. • Support scale-up of legal support services to enhance the rights of PLHIV, KPs, and other vulnerable populations.	**Malaria** • Invest in community systems to address malaria prevention and treatment literacy among the public including improvement in bed nets use. • Support malaria prevention and control advocates at all levels. • Invest in the recruitment of more health workers and increase community-based health workers (VHTs).
Tuberculosis • Support community systems strengthening through CSOs/CBOs to improve public knowledge about TB aimed at reducing stigma and improving adherence to treatment. • Develop an advocacy plan aimed at mobilizing public and policymakers towards prioritizing TB interventions at various levels. • Ministry of Health TB program should continue to invest time and resources in CQI through regular support supervision, capacity building of health workers and prioritizing better management of people with TB. • Invest in decentralizing TB/HIV services to lower-level facilities. • Set up a motivation plan for TB focal persons and increase the number of staff managing TB. • Increase investment in the infrastructure to provide adequate accommodation for TB inpatients	**Gender and human rights** • Since Local Council Courts play a significant role in promoting access to justice, they should be empowered to deal with violations relating to HIV&AIDS, GBV, and rights of KPs. • Support awareness creation among people living with, affected by, and at risk of HIV of their rights and entitlements. • Within the realm of direct service delivery, government and other partners should integrate a rights component for patients and others affected within existing health service delivery programs. • Legislative and policy advocacy is required to address the deficiencies in various HIV policies and laws to secure the formal conclusion of rights-based policies and laws, and ensure enforcement of rights-based policies and laws. • Support institutional and programming capacities of most organizations working at the intersection of HIV, human rights and laws.
Reproductive Maternal, New-born, Child and Adolescent Health (RMNCAH) Services • Invest in health promotion and disease prevention interventions to reduce the disease burden and increase funding to address the gaps in health service delivery. • Improve cervical cancer screening and focus on reducing barriers and enhancing facilitators through measures such as raising awareness	**Key populations** • Revise the KP service package to include screening and immunization against hepatitis A and B virus; routine screening for cancers; routine assessments of drug, alcohol and tobacco use; screening for problems related to mental health, post-traumatic stress, stigma and discrimination. • Develop and disseminate materials that provide information to KPs on available services and safety

about the disease, strengthening health systems capacity, and using female health workers to carry out screening. • Build the capacity of available female health workers to carry out cervical cancer screening of women. • Health facilities should have adequate capacity including skilled and professional workforce and required supplies to provide quality screening services to women.	at facilities. • Provide information to the public to increase their understanding of KP issues and reduce isolation, stigma, and discrimination. • Provide information to service providers to ensure that they are informed of the key aspects of KP health.
Systems strengthening • Revise staffing norms to take into consideration the growing population and range of services provided. • Install running water and provide additional water storage units such that water can be harvested or stored. • Provide ambulances and motorcycles to support referral system and outreaches. • Construct more staff houses and renovate existing ones. • Provide communication equipment (suggestion boxes, telephone booths or public payphones, facility landlines, desk computers, and internet). • Avail more space to enable smooth consultation processes between patients and service providers. • Connect all facilities to the national electricity grid, or procure generators and solar panels.	

Recommendations for undertaking future Community scorecard assessments

1. Given the many diseases with a myriad of indicators, a single tool designed to collect client views will be insufficient to provide comprehensive views. Therefore, subsequent scorecard exercises should separate tools such that each disease/condition is covered as a module within the bigger scorecard exercise.
2. Since the exercise is resource-intensive, subsequent scorecard assessments should consider annual or semi-annual assessment per disease/condition. This would make more programmatic and financial sense to cover a larger number of health facilities and client categories.
3. Consider the use of electronic data collection; several data collection platforms are versatile. This will address the challenges of delayed data collection, but also have data in real-time to ensure that errors or missing information is addressed immediately. Most applications that can be used have an inbuilt system to provide automatic checks and can flag any inconsistencies. All data uploaded on the smartphones would be automatically synchronized to a central server for data editing, processing, and analysis.
4. Consider the alignment of preliminary dissemination of results in the fieldwork plan to ensure that immediate validation is achieved before leaving the field.

CHAPTER ONE – INTRODUCTION AND BACKGROUND

1.0 Introduction

This report presents the results of the assessment undertaken by the International Community of Women Living with HIV Eastern Africa (ICWEA). It aimed to to track, document and report on availability, timeliness, accessibility and quality of HIV, TB, Malaria and RMNCAH, gender and human rights services. The assessment was undertaken between September 2019 and October 2020.

1.1 Background to the study

As part of the dual-track financing, the GFTAM provided funds to the AIDS Support Organization (TASO) Uganda Ltd as the non-public sector Principal Recipient (PR). It aimed to develop or/adapt existing scorecards as part of the priority interventions to strengthen community-based monitoring for accountability in 56 targeted Districts within the 2018-2020 funding cycle. This was aimed at improving Resilient and Sustainable Systems for Health. Consequently, TASO provided funds to the Uganda Network on Law Ethics and HIV&AIDS (UGANET) as a Sub-Recipient (SR) and leading a consortium together with the International Community of Women Living with HIV Eastern Africa (ICWEA) and the Human Rights Awareness and Promotion Forum (HRAPF) to implement a set of activities contributing to the attainment of GF objectives in Uganda. One of the activities undertaken building capacities of national and district level networks of people living with or affected by the 3 diseases to use community score and a report card (CSRC) to track, document and report on availability, timeliness, accessibility and quality HIV, TB, Malaria, RMNCAH**,** gender, and human rights services*.* The assessment was conducted between Sept 2019 and Oct 2020.

1.2 Report Structure

This report is organized into nine chapters. Chapter One gives introduction to the assessment, objectives of the assessment, a snapshot of the national health systems regarding HIV, TB, Malaria and RMNCAH, gender, and human rights services. Chapter Two presents the methodology used to conduct the assessment; the assessment results covering all disease and condition results are entailed in Chapter Three to Chapter Eight presents the assessment results. Chapter Nine presents recommendations.

1.3 Objectives of the Assessment

The overall objective of the assessment was to document and report on availability, timeliness, accessibility, and quality HIV, TB, Malaria, RMNCAH, gender, and human rights services across the study health facilities. Specifically, the assessment aimed:

a) To generate and compile community level views on the quality of HIV, TB, Malaria, RMNCAH, gender, and human rights service delivery.

b) To adopt any of the existing scorecard tools to include a minimum set of indicators for monitoring the 3 diseases and their conditions, gender equality processes, RMNCAH, and human rights entitlements in health service delivery

c) To generate recommendations aimed at enhancing social accountability in the health service delivery in Uganda.

1.4 Health care delivery system

Health care services in Uganda are delivered by both public sector (government) and private entities, including private-not-for-profit (PNFP) and private-for-profit (PFP) organizations, civil society, and complementary health service providers such as the traditional medicine providers. The public health facilities contribute 55% of the total health care facilities in Uganda, while PNFP and PFP contribute 16% and 29%, respectively. In Uganda, the Ministry of Health (MoH) performs the national level stewardship function. In the public sector, health services are delivered through the national referral hospitals, regional referral hospitals, and district health services, including general hospitals and health centers (IVs, IIIs and IIs).

The district-level health service includes the district health management team, general hospitals, and an array of primary care facilities (health centers (HCs)). The district health service is under a District Health Officer who is appointed by and accountable to the district local government. Because the decentralized system of governance adopted in 1995 devolved most functions and powers to districts, the district health services are administratively independent of regional hospitals and report directly to the MoH. The health system is organized at both the national and sub-national levels.

a) National Level: The MoH provides a leadership role and is responsible for delivering the outputs of all strategic plans for the health sector. Other stakeholders including both public and other non-state actors have defined roles to play in the delivery of health services. The MoH defines the functions and responsibilities of each level of health care and sets the minimum service standards and staffing norms for each level.

b) District Health System: The District Health System (DHS) encompasses public and private general hospitals, health centers, and community health programs. Local Governments have the responsibility for the delivery of health services, recruitment, and management of the personnel for district health services. Besides, they are tasked with the development and passing of health-related byelaws, planning, budgeting, and resource mobilization and allocation to health services.

c) Health Sub-District: Within the district, the health system is further subdivided into health sub-districts (HSDs) that have headquarters at level IV of the health center or general hospitals. The HSD provides overall day-to-day management and technical oversight of the lower-level health facilities (HC level III and II, and community level) within its jurisdiction. It also provides leadership in the planning and management of health services including supervision and quality assurance within the HSD; and technical, logistical, and capacity development support to the lower health units and communities, including procurement and supply of drugs.

d) Health Center III and II: HC IIIs provide basic preventive and curative care as well as providing support supervision of the community and HC IIs under their jurisdiction. These are responsible for the provision of laboratory services for diagnosis, maternity care, and first referral cover for the sub-county. The HC IIs provide outpatient care, community outreach services, and linkages with Village Health Teams (VHT). Health workers at HC IIs supervise and mentor the village health teams (VHT), provide medicines and other commodities, and receive referred cases from the VHT level.

e) Community Level: In Uganda**,** Health services at the community level are provided by community health workers referred to as Village Health Teams. The VHTs are responsible for health promotion activities, community mobilization to improve health-seeking behavior, disease prevention, and adherence to treatment. In 2010, Uganda adopted the Integrated Community Case Management (ICCM) strategy where two of the five VHTs members are responsible for the diagnosis and treatment of common childhood illnesses, including malaria, pneumonia, and diarrhea in addition to the preventive platform.

1.5 A snapshot of the Demographics in Uganda

According to the 2014 Population and Housing census, Uganda has a population of 34.9 million and an average annual population growth rate of 3% (UBOS, 2014). The average household size is 4.7 persons, with a sex ratio of 94.5 males per 100 females. An estimated 72% of the population lives in rural areas and 28% in urban centers. Forty-nine percent (49%) of Uganda's population is under the age of 15 and 18.5% of the total population is under five years. The life expectancy at birth is 63.3 years (UBOS, 2014). The demographic data are summarized in Table 1 below.

Table 1: Uganda's Demographic data - 2014

Population	Number in Millions	%
Total	34.9	100
Children aged 0-59 months (under 5 years)	6.6	18.9
Women of reproductive age (15-49 years)	7.3	20.9
Population below 15 years	17.0	48.7
Population of adolescents (10-19 years)	8.6	24.5

Source: UBOS 2014

According to the global estimates on the burden of disease (2016), HIV, malaria, lower respiratory infections, neonatal encephalopathy, and tuberculosis still cause the highest number of years of life lost in Uganda. The five killer diseases on their own are responsible for just under half (48%) of all mortality in Uganda. Overall, there has been a general improvement in mortality rates in Uganda over the past decade. The Infant Mortality Rate (IMR) declined from 75 to 43 deaths per 1,000 live births between 2006 and 2016, while the under-five mortality rate (U5MR) declined from 137 to 64 deaths per 1,000 live births. Over the same period, there has been an observed decline in the maternal mortality rate from 438 in 2006 to 336 in 2016 per 100,000. Although the country has experienced declining mortality rates, there are significant spatial variations, highlighting inequalities in mortality by geographic location. Risk factors associated with high mortality under-five entail the number of under-five year-olds in the household, marital status, education level of the mother, ownership of electronic assets, and shelter. With intensified efforts to improve the health status, there is likely to be a further reduction of mortality in Uganda. Table 2 shows the status of key health indicators based on the UDHS 2016.

Table 2: Status of key health indicators based on the UDHS 2016

Indicator	2016 value
Under-five mortality rate/1000 live births	64
Infant mortality rate/1000 live births	43
Maternal mortality ratio/100000 live births	336
Neonatal mortality rate/1000 live births	27
Stunting among children under five years (height-for-age < -2SD)	29
Acute malnutrition in children under five years (weight- for- height < -2SD)	11
Total fertility rate (15-49)	5.8
Delivery under a skilled attendant	74%
HIV prevalence rate	6.3%

1.5.1 HIV/AIDS situation

Overall, Uganda has made much progress towards the national and global targets and commitments to the treatment targets of 90-90-90 by 2020 as part of an effort to fast track the end of the HIV epidemic by the year 2030. According to the Uganda HIV&AIDS Country Progress Report for July 2016-June 2017, the national HIV Testing Services were scaled-up and the program registered ten million people accessing testing and counselling services up from eight million in 2015. Furthermore, the report cites that 73% of the adult population knows their HIV serostatus.

The recent Uganda Population-based HIV Impact Assessment (UPHIA) 2017 indicated that the prevalence among adults for HIV is 6.3% with West Nile having the lowest rate of 3.1% and South Central with the highest, at 8.0%. Concerning testing, 46% of men and 55% of women reported having tested for HIV in the past twelve months while just under half (49%) of adults had comprehensive knowledge of HIV. Viral load suppression among PLHIV stands at 60%. According to The Presidential Fast Track Initiative (PFTI) 2018, 1.3 million Ugandans with 95,000 children are living with HIV. The trend of new HIV infections (incidence) has continued to decline with new infections falling to an all-time low of approximately 46,487 in 2017 from 51,528 in 2016. The number of children born with HIV infection in Uganda declined by 86% between 2011 and 2016, while annual deaths from HIV&AIDS reduced from 21,773 to 20628 between 2016 and 2017, respectively. The report indicates that a total 1,070,062 (80%) PLHIV are currently enrolled in care and treatment, out of which 67,413 are children. For eMTCT, the Uganda HIV&AIDS country progress report for July 2016–June 2017 indicated that 31% of couples tested together and received results. Furthermore, out of the 102,593 mothers identified as HIV positive, the report indicates that 99,128 (97%) were started on ART for eMTCT, and only 71,867 (70%) of the Exposed Infants had their first DNA test.

1.5.2 RMNCAH

The Uganda Demographic and Health Survey indicated that the maternal mortality ratio is 336 out of every 100,000 women/girls, 60% of pregnant women had at least four antenatal care visits during their last pregnancy, while 73% delivered in a health facility. According to the 2016/17 health sector annual performance report, most women who attended Antenatal Care (ANC) for their most recent pregnancy had a blood sample taken (93%), were weighed (88%), had their blood pressure measured (72%) but were less likely to have a urine sample taken (39%). Furthermore, whereas data from the Health Management Information System (HMIS) shows that 54% of pregnant women attended ANC in 2017 and received IPT2, data from the 2016 UDHS shows that 46% of pregnant women attended and received 2 or more doses for IpTp, which is still way below the national target of 71% by 2020. IPT2 coverage was lowest in Iganga (33.9%), Manafwa (30.9%), Bududa (28.7%), Kole (26.5%), Buvuma (24.9%) and Wakiso (22.3%).

According to UDHS 2016, the Contraceptive Prevalence Rate (CPR) for modern contraceptive methods among married women improved from 26% in 2011 to 35% in 2016. The unmet need for family planning declined from 34% in 2011 to 28% in 2016, while in 2016/17, 2,156,240 Couple Years of Protection (CYP) were provided. Unmet need is highest in the regions of West Nile (43%) and Acholi (39%), while the most popular method among women is the implant and injectable. In terms of informed choice, 53% of all women currently using modern contraceptives were informed about the entire method information index at the time they started the current episode of use (the side effects of the method, what to do if they experience side effects, and other available methods). According to the UDHS 2016 report, women obtaining a method from

the public sector were more likely to be informed of the entire method information index (60%) than those who obtained their method from the private sector (42%).
The Ministry of Health's sharpened plan for RMNCAH, the major strategy for child health, is to stop preventable newborn and children under five deaths by increasing equitable coverage of high impact evidence-based interventions to accelerate the attainment of Sustainable Development Goal (SDG) 3 and promote appropriate nutrition and proper growth and development of children and adolescents. Statistics indicate that child mortality halved over the 10 years with the infant and child mortality declining from 71 and 128 in 2006 to 43 and 64 in 2016, respectively. The report also notes an observed increase in vaccination coverage from 46% to 55% of children aged 12-23 months receiving all the basic vaccines. With regard to other health-seeking behaviors, about 40% of children with symptoms of malaria and ARI sought treatment within the same day of getting the symptoms.

1.5.3 Tuberculosis

Tuberculosis (TB) is one of the main causes of illness and death globally, accounting for an estimated 8.8 million new cases and 1.6 million deaths each year. TB remains a major public health problem in Uganda, which puts it among the 22 high burden TB countries in the world that contribute to 80% of the global TB burden [WHO, 2016 Global TB Report]. The 2014/15 TB prevalence survey conducted by Makerere University School of Public Health established that TB prevalence is higher than had been previously reported; about half of TB cases are not recorded each year. HIV/TB co-infection rate is 42% and is estimated to be three times higher in non-HIV positive persons. The survey also indicated there is gross lack of awareness about TB at the community level, calling for the creation of more awareness programs. After adjusting for all age groups and extra-pulmonary TB, the prevalence of TB was found to be 253/100,000 equivalent to 87,000 TB cases per year, which is twice the number reported through routine health statistics. This implies that smear microscopy, the main TB diagnostic test in the country, misses about 60% of the cases, and CXR picked about 50% of the confirmed TB cases.

However, the Ministry of Health has promoted new smear-positive case detection and subsequent treatment of the patients. The TB treatment success rate improved from 70 percent in 2011/12 to 80 percent in 2016/17. This is still below the HSDP target of 84 percent. The TB case detection rate increased from 39 percent in 2011/12 to 50 percent in 2016/17. The 2015 survey (UBOS, 2018) findings point to a need to update the country's TB screening and diagnostic algorithms. The report notes that the much higher TB prevalence in men and the highest prevalence to notification ratio among the adolescents and young adults point to the need to develop strategies to diagnose TB in these sub-populations.

1.5.4 Malaria

According to the Ministry of Health's 2016/17 Sector Performance Report, malaria remains the leading cause of death among infants, under five years. It is also responsible for 26.8% of hospital-based under-five deaths, followed by anemia (13.6%), pneumonia (13.1%) and neonatal sepsis (7.3%). The report indicated that between 2016 and 2017, inpatient malaria deaths decreased from 22 per 100,000 to 20 per 100,000 albeit far below the health sector 2015/16 to 2019/20 strategic plan and malaria reduction strategic plan target of 5 per 100,000. Similarly, the number of malaria cases per 1,000 persons increased to 433 per 1,000 in 2017 from 408 per 1,000 in 2016. Apart from the malaria epidemic and the high incidence of malaria in several districts, non-adherence to test results remains a major challenge as indicated in the performance report.

1.5.5 Gender and HIV&AIDS

HIV prevalence in Uganda depicts gendered patterns in terms of driving factors and impact. Women and girls in Uganda continue to face disproportionate risk to HIV infection due to biological, social, cultural, economic and other factors. According to the UPHIA study (MoH and ICAP, 2017), the prevalence of HIV among the adult population aged 15-64 is higher among females (7.6%) compared to males (4.7%). HIV prevalence is almost four times higher among females aged 15-19 and those aged 20-24, compared to their male counterparts (MoH and ICAP, 2017). In 2017, new HIV infections in the general Ugandan population had increased among females (25,966) constituting 56% compared to males, 20,521 (44%). Among young people aged 15-24 who account for over one-third of new infections, 73% of the infected were females compared to 27% males (UAC, 2018).

1.5.6 Gender Inequality

Gender inequality is deeply rooted in Ugandan cultural norms and practices and has a profound effect on the SRHR and HIV outcomes of women and girls. The socio-economic conditions for women are difficult and the majority of women have limited access to sustainable livelihoods or employment, which renders most of them poor. Owing to unequal gender relations within the home, many women play a minimal role in decision-making, particularly when it comes to matters of household expenditures including expenditures on health. Moreover, expenditure on women's health is not considered a priority in many homes. Besides, due to the institutionalized systemic unequal power relations in society; women and girls generally do not make choices and decisions over their bodies, which affects their ability and capacity to negotiate sexual matters.

Women have complex SRHR needs; however, the majority cannot afford private health care and rely on government-run health centers and hospitals. These facilities are often overcrowded; lack specialized personnel; and routinely experience stock-outs of key health commodities such as contraceptives. In many cases, women are inadequately informed about their health rights, available health services because of low levels of literacy and cultural norms.

In addition to the barriers that women face in accessing quality SRHR services, women's health outcomes are partly determined by their ability to decide how, when, and with whom they engage in sexual relations. Agency in sexual aspects of life is limited for many women and girls in Uganda owing to their low status and a lack of power to negotiate with men. The AIDS Indicator Survey (2011) confirmed that while there is growing acceptance that women should be able to negotiate safer sex with their sexual partners, urban women and men are more likely to accept women's rights to negotiate safer sex than their rural counterparts. The proportion of women and men who support women's ability to negotiate the terms of sexual relations was noted to increase with education levels and wealth quintile.

The survey shows that women and men in Uganda believe that a woman is justified in asking her husband to use a condom if she knows he has a sexually transmitted infection. However, it is concerning that both sex were less supportive of a woman's right to refuse sex if she knows he has sex with other women or men. In each situation, women were less likely to feel that a wife is justified in negotiating safer sex when her husband/partner has multiple partners than men. This finding is especially important because it is known that biologically, a woman is twice more likely to contract HIV from a man than a man is to contract HIV from a woman. Cultural practices such as paying of bride price contribute to men's perception that women have no right to refuse sex under any circumstances. Polygamy, a well-accepted practice, particularly in rural areas also contributes to women's higher risk of acquiring HIV and other STIs.

1.5.7 Human Rights

The adopted HIV Prevention and AIDS Control Act (HAPCA) 2014 contains some useful provisions. It requires pre-test and post-test HIV counselling; stipulates that HIV treatment is a state responsibility and provisions against discrimination in access to employment and other social opportunities on the ground of HIV status. However, the Act limits or removes human rights protections for PLHIV such as mandatory or routine HIV testing, disclosure of HIV test results to third parties, and criminalization of intentional and attempted transmission of HIV.

Currently, there is inadequate legal protection for sexual and gender minorities, sex workers, and drug users. Stigma and discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) persons, Sex Workers, Drug Users and PLHIV, in general, has been increased by the enactment of repressive laws. Some of these laws include The Constitutional Amendment (No. 2) Act of 2005, The Public Order Management Act (POMA), The Anti-Pornography Act 2014, The HIV Prevention and AIDS Control Act 2014, The Non-Governmental Organizations Act 2016, The Narcotic Drugs and Psychotropic Substances (Control) Act 2015 and the Registration of Persons Act 2015. Others are the 2015 Ministry of Health Standards and Guidelines on Reducing Morbidity and Mortality from Unsafe Abortion in Uganda that challenge access to and provision of services and enjoyment of fundamental human rights. These legal frameworks and guidelines coupled with the social and religious connotations further fuel stigma and discrimination; affect access to various services; and hinder health service providers from providing health services. They also affect how CSOs work, increase human rights violations, and lead to denial of justice. This not only affects their ability to access services but also creates a need to respond to promote and protect the rights of marginalized groups.

Although the Anti-Homosexuality Act (AHA) 2014 was declared unconstitutional, it was a part of the discriminatory environment that prevails in Uganda. Public reaction and response to the Act demonstrated the serious impact that discrimination can have on service delivery and advocacy related to human rights. Nullification of AHA was a great achievement but negative consequences remain for some of the most vulnerable populations in Uganda. Health service providers are still not sure about how to serve the needs of criminalized key populations without contravening the law or themselves incurring criminal liability. Although there has been recognition of key affected populations in HIV program planning, not all responses that are planned are rights-based and enabling. For example, there is an emphasis on encouraging sex workers to find alternative forms of work as opposed to focusing on risk reduction and empowerment. Moreover, planners and service providers are still reluctant to associate themselves with key populations, especially sexual minorities. The persistent threat that legislators will pass punitive laws that further criminalize key populations continues to alienate key populations from their communities and from the services that they need; this increases the likelihood of their rights being violated. In addition, these threats create cycles and waves of violations targeting key populations.

1.5.8 Stigma and Discrimination: People Living with HIV (PLHIV) and Key Populations that have high unmet needs for SRHR and HIV services often have some of the lowest levels of access because of stigma and discrimination. For example, sex workers, men who have sex with men (MSM), and people living with HIV (PLHIV) report poor treatment and denial of services by health workers. Stigma within communities and health settings is layered and complex; it can lead to other attitudes or prejudices relating, including homophobia, transphobia, classism, and sexism. These prejudices will further lead to lack of interest within mainstream human rights organizations, health, and legal aid service providers to meet the unmet SRHR needs of sexual and gender minorities. At an individual level, stigma attaches itself to one or more axes of a person's intersecting identities, including HIV but not excluding other dimensions such as race, gender identity, and/or sexual orientation. We know that stigma adversely affects how and when someone can access SRHR and HIV services, how people interact with each other (including friendships, intimate

partnerships within communities and professional relationships), and how someone perceives him/herself and their self-esteem. Stigma poses a real threat to the realization of human rights; therefore, there is need for intervention to tackle stigma and discrimination within health care settings, in the community, and with duty bearers.

1.6 THE COMMUNITY SCORECARD MODEL

The Community Score Card (CSC) is a participatory process that empowers communities or service beneficiaries to influence the quality, efficiency, effectiveness, and accountability in service provision at the local level. The information in the scorecard is used to improve service delivery in communities to support advocacy, and develop better monitoring and evaluation of the HIV response. The CSC method was chosen among other social accountability monitoring tools (citizen report card, social audit, and national dashboards) because it provides a holistic and hybrid dimension that brings together duty bearers, various service users and service providers. It solicits social and public accountability and responsiveness from service providers by linking service providers and leaders to the community, thereby empowering citizens to provide immediate feedback to the service providers and leaders.

1.7 Justification and benefits of the Community Score Card

In order to track progress against the project goals and targets, a deliberate effort to track performance must be invested in. Secondly, there is a need for an instrument that allows extraction of information and views from the community for purposes of social and public accountability and responsiveness from service providers. Therefore, the effort of developing and implementing Uganda expanded community scorecard is in line with global initiatives including A Promise Renewed (APR), and UN Commission on Information and Accountability among others. Under the APR initiative, the Ministry of Health and partners are progressively institutionalizing a national level community scorecard that tracks the social accountability from community members. The CSC process uses the "community" as its unit of analysis and is focused on monitoring at the local level. Thus, it facilitates the monitoring and performance evaluation of health services delivery by the community themselves. Since it is a grassroots process, it is also more likely to be of use in a rural setting; therefore, it is aimed to improve the overall quality of service delivery in the community.

The completed CSC tracks and measures critical service delivery indicators in each of the key thematic areas for the three disease conditions (Malaria, TB, and HIV) in addition to human rights, gender, and RMNCAH. Furthermore, the scorecard helps stakeholders to compare progress against national targets, and highlights key issues affecting the progress of achievement for planned targets and identify action items. It also enables learning from stakeholders and communities, indicates aspects of the programs that are working well and those that are not, and supports decision-making and policy choices for improved service delivery for the health sector specifically for the three disease conditions.

Summary of the uses and *uniqueness of Community Scorecard from other surveys*

- Creates opportunities for information sharing, mutual objective and critical assessment of service quality, effectiveness and efficiency, and joint decision-making.
- Promotes good governance in health services with emphasis on participation, rights and obligations, and equity in the delivery of services.

- It is more participatory: it enables citizens to voice their assessment of priority public services
- Strengthens the monitoring and evaluation function. The process of scoring and monitoring aspects of service delivery motivates service providers to measure and improve their performance.
- Presents the self-reported data provided by all stakeholders in a transparent manner.
- Promotes discussion and dialogue between service users and service providers to build community empowerment and strengthen citizen's voices.

Therefore, the CSC increases participation, accountability, and transparency among service users, service providers and decision-makers.

1.8 The goal and core strategy of the community scorecard

The main goal of CSC is to influence positively the quality, efficiency, and accountability within which services are provided at different levels and for different community groups and locations. The core implementation strategy to achieve the goal is the use of dialogue in a participatory forum that engages service users and service providers as well as decision-makers.

The community scorecard methodology generally includes or follows through six key stages designated to achieve the intended objectives and outcomes. It is important to highlight the need to understand the context in which services are delivered, particularly, the main actors in service delivery, and the institutional environment and political culture that may support or inhibit the effectiveness of service delivery.

- **The Community Scorecard is NOT:**
- About finger-pointing or blaming/accusing
- Designed to settle personal scores/disputes
- Supposed to create conflict and disharmony between service users and service providers

CHAPTER TWO – METHODOLOGICAL APPROACH

2.0 APPROACH AND METHODOLOGY

This chapter presents the community scorecard approach that was employed in undertaking the assessment. It details the design and geographical study areas; study participants; and methods of data collection, processing, and analysis.

2.1 Design and geographical scope: The assessment/study took on a cross-sectional approach that employed mainly qualitative methods in selecting study areas, participants, and data collection. The CSC study was nation-wide covering all the regions of the country with a focus on 56 districts supported by the Global Fund (Table 3).

Table 3: Selected Districts for the Study

Sub-region	District
East	Tororo, Mbale, Bukwo, Kamuli, Buyende, Luuka, Kaliro, Jinja, Iganga, Bugiri, Namutumba and Busia
Greater North	Lira, Apac, Dokolo, Amolatar, Amuru, Pader, Lamwo, Kole, Otuke, Yumbe, Kitgum and Alebtong
South West	Rubirizi, Kisoro Mbarara, Bundibugyo and Ntoroko
North East	Abim, Kotido, Kaabong, Napak, Amudat, Nakapiripit,
Mid-west	Kasese, Hoima, Bulisa, Masindi, Kagadi, and Kyankwanzi
Central	Nakaseke, Nakasongola, Kiboga, Luwero, Kalangala, Buikwe, Buvuma, Kayunga, Kampala and Wakiso
Old Districts	Moroto, Arua, Guru, Kabalore and Mayuge

In the 51 selected districts, the study covered 156 health centers from level III to IV including one referral hospital. These facilities were randomly selected from all public health facilities.

2.2 Sampling process

Health facilities were randomly selected from the MoH 2018 health facilities inventory. Regional Referral Hospitals, health center IVs and health center IIIs were selected in each district (where it applied); and 156 health facilities were sampled in the 51 districts.

The study participants were sampled using Morgan and Krejcie (1970) sample selection theory; beneficiaries were randomly selected from the communities that live in a radius of 5 kilometers of the selected health facilities

2.3 Study participants

The participants studied included clients, who accessed services at the selected health facilities during the previous three months preceding the study, and duty bearers. The service users included PLHIV, pregnant and lactating women, caregivers of children, adult men, young people, and key populations (sex workers, people who use drugs, LGBTIs, and fisher folks). The duty-bearers encompassed health facility in-charges and members of the health management committees, District Health Officers, CDOs, representatives of CSOs/CBOs/implementing partners and the political leadership of the districts.

2.4 Data collection methods

The study mainly used qualitative methods to gather views from the respondents and the major techniques employed are described below.

a) **Document review:** The assessment team reviewed both national and international literature and documents related to community scorecards for purposes of preparing a comprehensive community scorecard methodology and tools for health service delivery. Examples of scorecards developed in Uganda include the TASO, for the first phase of implementation of the scorecard in 2018, ACCORD, UNASO, UNHCRO, and UGANET among others. Specifically, the review focused on the current and past trends, issues with community scorecards, current indicators to monitor minimum standards, and stakeholders at national, district and community levels engaged in the delivery of health services. It reviewed relevant health service delivery policy and strategy documents. The team also reviewed the existing community-based scorecard tools, reports, and guidelines at the global, regional, and national levels focusing on monitoring health service delivery of the three diseases, gender equality processes, and human rights entitlements. The product of this document review was used to improve scorecard data collection tools and methodology.

b) **District stakeholder entry meetings:** District stakeholder meetings were held before data collection. These meetings brought together local government leadership including Resident District Commissioners, LCV executive committee members, the technical team headed by the Chief Administrator, and some of the local health intervention partners. This platform created an opportunity to learn about the community scorecard process and the health facilities to be visited.

c) **Key informant interviews**: Key informant interviews were conducted to understand the perceptions and attitudes towards health service delivery at the community, district, and national levels. Key informants were selected based on their influence in decision making for availability and delivery of health services for the diseases (HIV, TB, and Malaria) which were under assessment. Their ability to articulate in detail the challenges operating at different levels of the health service delivery system was also taken into account. The key informants included health facility in-charges and members of the health management committees, District Health Officers, the CDOs, representatives of CSOs/CBOs/implementing partners and the political leadership of the districts. The key informant interviews were conducted using a semi-structured interview guide.

d) Focus group discussions

To collect feedback about the quality of service delivery from the community members, we used focus group discussions of between 8 and 10 members. The FGD categories included women inclusive of adolescent girls, men inclusive of adolescent boys, key populations, and health workers. The Client Score Card Matrix (**Appendix V)**, which contained indicators as approved by the CSC technical working group, was administered to these groups of people during the FGDs and they scored the services and provided reasons for the scores and recommendations for improving the service.

e) **Input Tracking Scorecard:** Using staffing norms checklists, observations around the selected facilities as well as the checklist for equipment inventory assessment, the team collected information on the various resources required to deliver the health services, the required quantity/standard, and the actual quantity at the service delivery site. The process was completed by the assessment team

in collaboration with facility staff that provided information on what is in existence vis-a-vis the standards**.**

f) **Interface between community and service providers:** Once the community and service providers had separately assigned a score for services delivery based on the indicators approved, a joint meeting with both the clients and service providers was held to reach a consensus on the perceived quality of health services delivered at the selected health facilities. Following the agreed scores, the meeting came up with an action plan to improve services for the indicators that scored poorly.

g) **Community Score Card National Task Force:** The execution of the assignment, the consultancy team benefitted from technical guidance from the Multi-Sectoral Taskforce (National Task Force). The task force comprised of representatives of key government ministries, departments, and agencies; CSOs; and development partners. The team reviewed the methodology and data collection tools, provided information on sources of data, and individual task force members were interviewed as key informants. The task force also met several times during the subsequent processes of data collection and report writing to review the draft report, provide input and feedback, and validate and approve the report.

2.5 Quality control

A team of competent supervisors and research assistants with expertise in qualitative data collection were recruited. To enable both national team and field staff (district-based) conduct the assignment competently and efficiently, a four-day and two-day training sessions were conducted at the national and district levels, respectively covering study objectives, qualitative research methods with a clear focus on administering the tools, and the community scorecard methodology. A team leader supervised each cluster of districts. Furthermore, the tools were pre-tested in selected health facilities in Wakiso district on selected respondents to ensure content validity and reliability before actual data collection began by the national team.

A technical **National Task Force** team was put in place to play an oversight role and render technical guidance in the scorecard exercise. The Taskforce met from time to time to provide overall technical guidance and oversight of the process. The Taskforce provided significant input in redefining the methodology and strengthening the tools. All the subsequent drafts by the assessment team were shared with the Taskforce members that provided invaluable technical input. Data from the field were received and reviewed by the team leader and statistician. The data were reviewed for completeness and erroneous entries such as typos, missing data, inconsistency, and out of range entries. Where possible, the responsible field teams were contacted to correct any errors. Data with errors were treated as missing data during analysis. Quantitative and qualitative data was entered in excel and grid sheets, respectively. The entered data consolidated into one database and backed up on a memory stick.

2.6 Synthesis and analysis of scorecard findings

To compute overall scores, quantities analysis techniques providing a summary of the score by indicator, district, and community/health facility visited were used. Data from the scorecards was entered into the computer and analyzed using SPSS to generate average scores. These were interpreted in light of the explanations given by the respondents to arrive at the final scores. Information was presented in descriptive form backed with relevant quotations. The findings were presented using traffic lights colors. The results were disaggregated by district and facility level and color-codes ranging from very good to very poor.

1. Very poor	
2. Poor	
3. Average	
4. Good	
5. Very Good	

2.7 Validation and dissemination of the report findings

The draft report was presented to the National Task Force that provided input. Furthermore, the meeting provided an opportunity to disseminate the key findings from the whole exercise but most importantly providing key recommendations and issues encountered at all stages of the assignment. The meeting further provided input to the district-based reports that were finalized for final national dissemination.

2.8 Ethical considerations

The assessment was not subjected to any ethics body approval because it is not classified as human subject research. The team secured the introductory letter from TASO and ICWEA for the data collection teams to present to authorities in the study districts as a way of securing clearance. The communication specified the purpose and support needed by all respondents. The team further obtained approval from the district local government to visit health facilities and requested permission and consent from in charges of health care facilities and respondents in the FGDs to collect the data as per CSC requirements. Besides, district entry meetings were held before data collection. These meetings created an opportunity to learn about the community scorecard processes and the health facilities to be visited. During data collection, informed consent was sought and obtained, while verbal consent was sought from FGD participants. Anonymity of the participants was guaranteed and the assessment team ensured confidentiality of data collected.

2.9 Limitations and Constraints

1. This study is not exempt from social desirability or self-reporting biases, especially by health workers although we attempted to minimize this by use of several probing questions and collaborating their responses with service recipients.

2. The study was conducted in many health facilities (115) with many indicators in a short period. This resulted in missing cases; some indicators were not scored at some health facilities. Nevertheless, the number of indicators scored was enough (>85% response rate) to give us dependable conclusions.

CHAPTER THREE – FINDINGS

3.0 INTRODUCTION

This section presents results of the community score card focusing on five areas i.e. HIV&AIDS, Malaria, Tuberculosis, RMNCAH, Gender, and Human Rights. The report present results from 51 out of 56 districts because 5 districts were already done by the same consultants. The report has specific sections for KP interventions and some sections have special report on particular indicators of success.

3.1 HIV PREVENTION

The National HIV&AIDS Strategic Plan (2015/16- 2019/20) projected to reduce new HIV infections from 137,000 in 2014 to 39,774 by 2025. These reductions would translate into a cumulative 642,000 new HIV infections by 2025, down from an estimated 2.8 million new HIV infections that would occur if the current coverage levels don't change. In effect, this would avert 2,160,000 new infections between 2014 and 2025, which would translate into a 77% reduction in new HIV infections over this period. To achieve this level of success, Uganda would need to scale up the implementation of proven combination HIV prevention interventions to critical levels over the period. Expanding and scaling up of uptake of biomedical priority HIV interventions (SMC, EMTCT, PEP, PrEP and male and female condoms) to optimal levels was of high priority. Other measures recommended included scaling-up coverage of HCT for HIV prevention targeting the general population, KPs and vulnerable groups especially in identified hotspot areas; adoption of new HIV prevention technologies and services including Pre-Exposure Prophylaxis (PrEP); and **s**caling-up age and audience-appropriate SBC interventions including abstinence (A) and being faithful (B) to reach all population groups.[1]

The community scorecard was used to assess quality and availability of eMTCT, quality of VMMC, availability of condom (female and Male), HIV testing and counselling services, availability and accessibility of PEP services, availability and accessibility of PrEP, availability and access to condom compatible lubricants, and provision of IEC/BCC materials as indicators of HIV prevention.

3.1.1 Quality and availability of eMTCT

We assessed the level of male involvement; attitudes and competence of health workers to provide comprehensive HIV care; stock status of commodities; follow up mechanism; and community knowledge and understanding of the eMTCT program.

Table 4: quality and availability of eMTCT Services

Variable	District	Facility Levels			
		IV	III	III	III
Quality and accessibility to eMTCT	Tororo				
	Mbale				
	Bukwo				
	Kole				
	Otuke				
	Alebtong				

[1] National HIV/AIDS Strategic Plan 2015/16- 2019/20

	Dokolo				
	Apac				
	Amolatar				
	Amuru				
	Pader				
	Lamwo				
	Rubirizi				
	Kisoro				
	Ntoroko				
	Hoima				
	Bulisa				
	Masindi				
	Kagadi				
	Kyankwanzi				
	Nakaseke				
	Nakasongola				
	Kiboga				
	Luwero				
	Kalangala				
	Buikwe				
	Buvuma				
	Kayunga				
	Abim				
	Kotido				
	Kaabong				
	Napak				
	Amudat				
	Nakapiripirit				
	Kamuli				
	Buyende				
	Luuka				
	Kaliro				
	Jinja				
	Iganga				
	Bugiri				
	Namutumba				
	Yumbe				
	Kitgum				
	Mbarara				
	Bundibugyo				
	Kampala				

Source: Field Data

Table 4 depicts very good, good, and average performance. The main reasons given for the good performance included the test and treat initiative, integration of HIV services in antenatal care, public

education on eMTCT through radio programs, provider-initiated counselling and testing as well the availability of drugs for mothers whose test results are seropositive. Furthermore, mentorship of health workers and improved supervision by district and IP teams; community follow up by health workers and VHTS were mentioned as some of the reasons for well-performing eMTCT interventions.

> *There is good counselling by health workers whenever we come to antenatal services at the facilities; we are informed and educated before HIV testing is done; generally, services are available. Female participant, Chesower HCIII, Bukwo District.*
>
> *Most community people lack information, that's why we still have mothers delivering at the TBAs place in our area. Male Participant, Dokolo District.*
>
> *We liaise with implementing partners to help us carry out the mentorship of health workers and support health facilities when it comes to supporting supervision to ensure quality assurance in all health facilities. (KI, DHO Office, Kole District)*
>
> *"All mother-baby pairs are followed up through to ensure retention" (FGD Participants, Nabisoigi HCIII)*
>
> *"All mothers and their babies in eMTCT clinic are followed up and made sure that they are retained into care through the expert clients", FGD Participant, Nankoma HC IV, Bugiri District.*
>
> *"Availability of mentor mothers who follow up women from facility to grassroots even when they get lost", FGD Participant, Mayuge HC III, Bugiri District.*
>
> *"Services for eMTCT are being given. Though men don't come because of how slow the services are and they hate over waiting. Women who don't come for their appointment day are followed up on phone or physically. Though there are mothers who still have stigma and fear to be seen at the health facility"* FGD *Participant, Bugono HC IV, Iganga District.*

However, participants reported some challenges: loss for follow-up, failure of the mother to deliver in health facilities, and low male involvement affecting the uptake of eMTCT services. For some mothers, it was reported that transiting from antenatal care to HIV care clinics was a challenge due to fear of stigma and discrimination.

Respondents recommended strong male involvement in the eMTCT program and supporting linkage facilitation to sensitize communities and PLHIV on eMTCT for better results. In addition, maximizing the benefits of lifelong ART, adequate preparation of women before ART initiation, and on-going support through FSGs and male partner engagement are critical, particularly after birth and cessation of breastfeeding.

3.1.2 Voluntary Medical Male Circumcision (VMMC)

In September 2010, the Government of Uganda launched an initiative to provide VMMC as an essential health service in HIV prevention. The initiative seeks to increase the number of circumcised men by educating the population about VMMC, increasing the number of health facilities that provide VMMC services, and equipping health providers with the necessary skills to circumcise. The community scorecard

assessed community awareness, availability of VMMC, competent personnel in VMMC, community involvement and perception, follow up mechanisms and availability of VMMC kits.

Table 5: Quality VMMC Services

Variable	District	Facility levels			
		IV	III	III	III
Quality of VMMC Services	Tororo				
	Mbale				
	Bukwo				
	Kole				
	Otuke				
	Alebtong				
	Dokolo				
	Apac				
	Amolatar				
	Amuru				
	Pader				
	Lamwo				
	Rubirizi				
	Kisoro				
	Ntoroko				
	Hoima				
	Bulisa				
	Masindi				
	Kagadi				
	Kyankwanzi				
	Nakaseke				
	Nakasongola				
	Kiboga				
	Luwero				
	Kalangala				
	Buikwe				
	Buvuma				
	Kayunga				
	Abim				
	Kotido				
	Kaabong				
	Napak				
	Amudat				
	Nakapiripirit				
	Kamuli				
	Buyende				
	Luuka				
	Kaliro				

	Jinja				
	Iganga				
	Bugiri				
	Namutumba				
	Yumbe				
	Kitgum				
	Mbarara				
	Bundibugyo				
	Kampala				

Source: Field Data

The community attributed the performance of VMMC intervention to using public education mainly through mass media. The services were available whenever needed or whenever they asked for them. There was minimal stock out of testing kits. The gaps identified included poor community perceptions, inadequate one-on-one sensitization on the benefits of VMMC beyond HIV prevention, limited post-circumcision support from health workers, and insufficient community leadership in VMMC support. In addition, stigma and misinformation were also noted as some of the challenges affecting the intervention. Furthermore, it was reported that fear of pain, not believing that they were at risk of HIV, and lack of partner support deterred men from undergoing VMMC. The other reasons included fear of HIV testing, partner refusal, and reluctance to abstain from sex.

People say that before you are circumcised, you must first get a blood test; this [perception] is chasing away most people. In addition, myths and misconceptions seem to be a significant deterrent. (Female Participant, Mifunya HCIII, Nakaseke District)

> *I was created with the skin! Why do you want to remove it? - (Male Participant, Rugazi HC IV, Rubirizi District)*
>
> *Some people think that when they are circumcised, they will lack manpower; they will feel a lot of pain during sexual encounters and won't get HIV/AIDS. (Female participant, Buhanika HC III, Hoima District)*
>
> *Some community members were concerned about infertility that may arise from circumcision. My major worry is whether we will still be able to have children after circumcision. (Male Participants, Nyarusiza HCIII, Kisoro District)*
>
> *"The VMMC services are available both static and in community through outreaches" FGD Participant, Nankoma HC IV, Bugiri District.*
>
> *"VMMC services were provided only once in 2019" FGD Participant, Loroo HC III, Amudat District.*
> *"The circumcision service is always available at any time someone wants to be circumcised. Mobilisation is done, though there are lots of myths and misconception that manpower goes down when one is circumcised. Some believe in only religious customs like Muslims and cultural customs" FGD Participant, Bugono, HC IV, Iganga District.*
>
> *"The uptake is low due to misconception of weakened manhood" Tokora HC III, Nakapiripit District*

It was recommended that VMMC demand-creation messages be tailored for different ages and emphasize non-HIV prevention benefits such as improved hygiene and sexual appeal, and need to address men's fear of pain. Promoting VMMC among women is crucial because they appear to have considerable influence over men's decision to be circumcised.

3.1.3 Availability of Condoms (Male and Female)

Condoms were identified as the best means of HIV prevention. The community scorecard looked at promotion and awareness of condoms, knowledge of service points, availability, community uptake, services' usage, and community perception on condom use.

Table 6: Availability and accessibility to male and female condoms

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Condoms (Male and Female) Services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					

	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Almost half of the respondents rated the intervention's performance as "average" and this was attributed to community misconceptions and attitudes of men towards condom use, stigma associated with use of condoms and poor communication among partners. Coverage and availability of female condoms remained key barriers to consistent condom use as reported by participants. Participants reported that the good performance was due to awareness and mass education about condoms in the community, availability of condoms at the facility and community outlets.

> *In our community, men are more powerful. Since he is stronger, whenever he wants sex, he initiates it. He says, it is he who suggested it and that I must agree! Women are more of respondents rather than initiators of sexual activity. 'We are embarrassed when we are face to face, that is why we do not use the condom'. A woman wants the man to enjoy himself. (Female Participants, Bufumbo HCIV, Mbale District)*

> *Women are not using female condoms because of fear associated with asking for a female condom. Besides, men don't want to sleep with women who use female condoms. (Male Participant, Bukomero HC IV. Kiboga District)*

> *Women don't use condoms; they instead use them as bracelets. Men also misuse them by giving them to children to use for shooting birds. (Health Worker, Pajule HC IV, Pader District)*

> *"In the whole of last month, there was no condoms due to insufficient supply at the health facility"* FGD Participant, *Bumanya, Jinja District.*

It was recommended that mass sensitizations on condoms use to address gender norms and skills to overcome HIV risk behaviours in efforts to dispel psychosocial barriers to condom use be intensified. In addition, more community outlets for the distribution of condoms should be identified.

3.1.4 AVAILABILITY OF FEMALE CONDOMS

An attempt was made to study availability and accessibility to female condoms after the initial phase has indicated that there are serious challenges with access to the female condoms compared with male condoms. Below, we summarize the findings

Table 7: Results for the availability of Female Condoms Services

			Facility Levels	
Variable	**District**	**HC III**		**HC IV**
Availability of Female condoms	Abim			
	Kotido			
	Kaabong			
	Napak			
	Amudat			
	Nakapiripirit			
	Kamuli			
	Buyende			
	Luuka			
	Kaliro			
	Jinja			
	Iganga			
	Bugiri			
	Namutumba			
	Yumbe			
	Kitgum			
	Mbarara			
	Bundibugyo			
	Kampala			

Source: Field Data

The results show that availability of female condoms was rated very poor and poor across all the health facilities in all the districts assessed. This performance was attributed to the following reasons; female condoms are not available, lack of awareness about female condoms in the community and misconceptions.

> *"Some people in the community have never seen the female condoms. They don't know how they look like" Namakora, HC, Kitgum district.*

> *"I have never seen them even don't know their colour" Female FGD Participant, Nyakwae HCIII, Abim district.*

> *"Women fear to use the female condoms. They have great phobia to use them even when health workers sensitize them during ANC and FP sessions" Health Worker FGD Participant, Balawoli HC III, Kamuli district.*

The participants recommended creating more awareness on the use of female condoms and ensuring supplies at the health facilities.

Table 8: Availability of Condoms under KP Programming

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of condoms (males and females)	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

Respondents were satisfied with the availability of condom services. The respondents attributed the performance to the availability of commodities at health facilities and in the community through peer systems for KPs. However, respondents complained about lack of female condoms.

> *I haven't seen female condoms the many times I've come here and I have never been told that they exist; am not even sensitized where to get them from and how to use the commodities. (KP,* Majanja *HC III, Busia)*

3.2 HIV Testing and counseling services

According to the NSP 2018/2020 and NPAP, objective 2 stipulates ways of scaling up prevention including extending coverage and uptake of HTC and enhancing quality assurance to achieve the global target of 1st 90. Therefore, the community scorecard assessed availability of testing kits, pre and post counseling services, community awareness on the services and community programs on testing services, the existence of provider-initiated HTC, and provision of HTC as part of the integrated package for services targeting KPs.

Table 9: Availability of HIV Testing and counseling services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of HIV Testing and counseling services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					

	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents attributed the good performance to increased opportunities for testing through provider-initiated testing and counseling, integration of HCT in ANC and VMMC service delivery points, health workers' encouragement of couple testing and counseling, and follow up mechanisms that link facilitators and expert clients. However, it was noted that stock-outs of testing kits, limited human resources, limited male and youth involvement undermine the effective performance of HCT. Limited privacy due to lack of space in some facilities was also mentioned as one of the challenges.

Very few men visit health facilities; how will you use provider-initiated testing and counseling to get them? We need to conduct outreach services to find men in places where they meet such as community bars; however, we lack resources to undertake such activities. Otherwise, this testing will remain low among men. (FGD, Health Worker respondents, Kole District).

The ART clinic is exposed on the road; this limit us from visiting the facility, we fear to be seen by everybody at the facility… (Male FGD Participant, ATIAKA HC IV, Amuru District)

"The service is available, counselling done well, follow up done, kits are ever available, test and treatment done but the gap is majorly in the non-consideration of KPs and other vulnerable groups" FGD Participant Balawoli HC III, Kamuli District).

"HIV testing and counselling services are available but there is no trained counsellor", FGD Participant, Lotome HC III, Napak District.

"HIV counselling and testing services are available though there are issues of confidentiality" FGD Participant, Bumanya HC III, Jinja District.

"The HIV counselling and testing services are available but space for counselling services is not enough" FGD Participant, *Lukolo HC III, Jinja District.*

"HIV testing and counselling services are provided but counselling services are inadequate" FGD Participant, Namakora HC III, Kitgum District.

It was recommended that health workers, linkage facilitators and VHTs should reach out to communities and conduct mass testing, and ensure continuous use of mass media to reach out to the communities.

Table 10: HIV Testing and Counselling services under KP Programming

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
HIV Testing and Counselling services	Lira					
	Wakiso					
	Kasese					
	Busia					

Participants ranked the HTC services performance as "quite well". They largely attributed the good performance to the value of providing venue-based outreach and testing services in "hotspots" where people including MSM, FSWs, and transgender people meet and seek sex partners. The results indicate that this approach is effective in increasing testing uptake and case finding among KPs. The respondents further noted that peer-to-peer models have helped the majority of KPs access the services, ensuring adherence and retention to care.

We are more comfortable when offered services like HIV testing in our business areas like bars at night because no public is the insight to start talking about us like it happens in health facilities. Here, in our hotspots, the health workers are friendlier unlike in health facilities. (Female KP, Kasese District)

Respondents recommended that HIV self-testing could be more acceptable and effective if implemented among KPs and linkage to treatment because this method eliminates stigma and discrimination. However, it was noted that this would be more effective if those who test positive through self-testing will have active follow-up and access to a trusted KP-friendly community clinic that offers HIV treatment.

3.2.1 Availability of PrEP services

Uganda adopted PrEP as one of the biomedical prevention interventions. During 2018, PrEP was rolled out in a phased approach. The community scorecard inquired about community awareness about PrEP, its benefits and its availability at health facilities.

Table 11: Availability of PrEP Services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of PrEP Services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					

	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results indicated that the majority of the respondents ranked PrEP performance as "very poor" and/or "poor" implying that the service is unsatisfactory. This was attributed to a lack of awareness about PrEP, misconceptions, and stigma associated with taking the ARVs, and the knowledge gap among health care providers. Also because of the phased manner approach, most districts were yet to start providing PREP. Even in districts where PREP was being provided, most respondents mentioned that it was maily for KPs. Some participants reported that they have mainly heard about the service from NGOs.

> *Well, I have heard about it through a local NGO, they talked about some pre-exposure pills. In addition, I know it was an antiretroviral and I know it is being used as a treatment. (FGD Female Participant, Katikamu HCIII, Luwero District)*

> *"The facility is not accredited for the service and there is knowledge gap by both the health workers and community members", FGD Participant, Balawoli HC III, Kamuli District.*

> *"Health education needed as the service is available but few community members have heard about it" FGD Participant, Ikumbya HC III, Luuka District.*

> *"The health workers are the ones who are a problem, we go to communities and tell them about PREP and when young girls come to demand for it, they are told that is a medicine for PLHIV, and asked why they want to take it when they are HIV negative?" FGD participant Bwizibwera Health Centre -Mbarara*

The information regarding social barriers related to the disclosure of PrEP use emerged in FGDs. it was noted that some people were hesitant to ask for PrEP from anyone because of fears stemming from the potential stigma and discrimination that could be associated with their lifestyles or behaviors. In addition, it was noted that there were limited sites that offer PrEP

I am concerned about taking PrEP; people might assume I am promiscuous. (Male Participant, Bwijaga HCIV, Masindi District)

PrEP is a new drug among the beneficiaries and people are still struggling with the new drug. They argue that is if it is a long-life drug, it means that they are also HIV positive. So, there is need for sensitization for them to comprehend why it should be taken for life even though one is not HIV positive. (KI, Nakasongola HCIV)

It was recommended that there is a need for mass education to promote PrEP services across the country as a means to create public awareness among different stakeholders. Besides, service providers should be oriented to offer and promote uptake of quality PrEP services by people at substantial risk of acquiring HIV. The MoH should accredit more health facilities that offer PrEP services.

Table 12: Availability and accessibility of PrEP services by KPs

Indicator	District	Health Facility Level				
		RRH	IV	III	III	III
Availability and accessibility of PrEP services	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The majority of the respondents ranked availability and accessibility of PrEP services as poor implying that they were not satisfied with the service. The poor performance was attributed to lack of awareness about PrEP, and misconceptions and stigma associated with taking ARVs. It was noted that some people were hesitant to ask for PrEP from anyone because of fears stemming from potential stigma and discrimination that could be associated with their lifestyles or behaviors as KPs. Those who reported the performance as "average" attributed it to having access to PrEP at Drop-in Centers where they exist.

Because they find us in our hotspots, therefore, it is comfortable and they give us enough for instance 3 tins (KP Participant, Lira RRH)

3.2.2 Provision of IEC/BCC materials

One of the Strategic Actions for National HIV&AIDS Strategic Plan (2015/16- 2019/20) was to scale-up age and audience-appropriate SBC interventions, including abstinence (A) and being faithful (B) to reach all population groups. To achieve this, development, promotion, and distribution of appropriate IEC/BCC messages and materials were undertaken to reach different populations across the country. In this regard, the community scorecard inquired about the availability of IEC/BCC materials and messages targeting different population categories.

Table 13: Availability of IEC/BCC materials services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of	Tororo					

IEC/BCC materials services	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					

	Bundibugyo					
	Kampala					

Source: Field Data

Majority of the respondents ranked the provision of IEC/BCC services as very good and/or good implying that they were satisfied with the service. The performance was attributed to on-going mass education through media, health talks conducted by health workers, VHTs, IPs, and availability of IEC materials at the health facilities. However, there were concerns that while there are health talks by health workers at facilities, they were limited by time due to work pressure because of fewer health workers. In most districts also respondents were concerned about the school talking compounds that would fuel stigma and discrimination with such messages like, "AIDS KILLS"

> *"Health education is done in form of health talks but IEC materials and messages targeting KPs are not in place" FGD Participant, Balawoli HC III, Kamuli District.*

The key recommendation: health talks should continue throughout the days – as long as patients are available. The ministry of health was tasked to work with the Ministry of Education to address messages that fuel stigma and discrimination in schools. There is also a need to use more local language IEC materials for sensitization.

Table 14: Availability of KP responsive health promotion IEC

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of KP responsive health promotion IEC materials	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The majority of the respondents ranked that performance of availability of KP responsive health promotion IEC as unsatisfactory. This was attributed to a lack of KPs specific IEC materials in the community and at the health facilities. Participants recommended that stakeholders should integrate social norms programming in SBCC and IEC to fasten behavioral change, achieve general public awareness, and improve utilization of services for KPs.

3.2.3 Availability and accessibility of PEP Services

PEP refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. needle stick injury) or non-occupational (e.g. having sex with a seropositive partner without using a condom). Respondents were asked whether the community is aware of the benefits of PEP; whether the population that needs the service know where to find it, or whether outlets for the distribution of the commodity are available.

Table 15: Availability and accessibility of PEP services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability and accessibility of PEP services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					

	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Most of the respondents were satisfied with PEP services. The participants attributed this performance to accreditation of health facilities offering PEP and peer groups in the community. However, it was noted that there is limited awareness of the availability and importance of PEP services. In addition, in most districts it was noted that most rape cases are delayed through the police processes and by the time they reach the health facility, it is already past 72 hours that is the maximum time that PEP can be offered. There was a strong recommendation therefore for collaboration and partnership between the police and health facilities.

> *"Immediately when the exposed person comes to the facility is given PEP, even these warriors know about it" - (FGD Health Worker Participant, Kotido HCIV, Kotido District.*
>
> *"PEP services are available especially for discordant couples" FGD Participant, Lotome HC III, Napak District.*
>
> *"Health workers know about PEP and the service is available but beneficiaries don't know the service", FGD Participant, Buyaga HC III, Kamuli District.*

Table 16: Availability and Accessibility of PEP services for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability and Accessibility of PEP services	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

Results indicated that most respondents ranked that performance as average and very poor implying that the service was unsatisfactory. This was attributed to limited awareness about PEP. It was noted that some health facilities are not accredited to provide PEP and most of the PEP services are accessed by KPs through differentiated service delivery models such as DICs and community system of KPs (Peers system).

3.2.4 Availability and access to condom compatible lubricants

Participants were asked whether the community is aware of benefits of condom compatible lubricants; whether the population that needs the service know where to find it; and whether there are outlets for the distribution of the commodity/condom compatible lubricants.

Table 17: Availability and access to condom compatible lubricants

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability and access to condom compatible lubricants	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					

	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

> *"Even us health workers do not know them" FGD Participant, Orwamuge HC III, Abim District.*

> *"There is knowledge gap all through and the service is not available at the facility" FGD Participant, Balawoli HC III, Kamuli, District.*

> *"They are not available at the health facility and they have never been supplied" FGD Participant, Nambaale HC III, Iganga District.*

The results show that more than half of the participants were not satisfied with availability and access to condom compatible lubricant services. Respondents attributed this poor performance to lack of lubricants at health facilities and lack of knowledge about lubricants within the community. In almost of the facilities, respondents didn't know that lublicants could also be used by women – the perception was that they are only meant to be used by Key Populations.

Table 18: Availability and access to condom compatible lubricants for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability and access to condom compatible lubricants	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

According to the results, all respondents were unsatisfied with the availability and accessibility to condom compatible lubricants. They attributed this to lack of lubricants at health facilities, lack of knowledge about lubricants and stigma associated with lubricants not as a public health commodity for the general population. The commodity is tagged to MSM/Sex Workers; therefore, it becomes stigmatized. Consequently, respondents recommended that lubricants should be availed at the health facilities, distributed through the hotspots and peer-to-peer mechanisms. Awareness creation about the service should be conducted for both health workers and the public.

3.3 Willingness to utilize KP services

The CSC inquired about the willingness of key populations to come for services at various service delivery points. Table 18 below presents the findings.

Table 19: Willingness to utilize KP services

Indicator	District	Health Facility Level

		Referral	IV	III	III	III
Willingness to utilize KP services	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The majority of respondents (KPs) agreed to the use of the health services. However, they noted that due to the criminalized and stigmatized nature of KPs in the country, sex workers, MSM, PWUID, and transgender people are often afraid to visit healthcare facilities for services. Whenever they visit, they are reluctant to disclose their sexual histories for fear of rejection, being scorned at or other negative reactions from health workers. In addition, the perpetration of violence against other KPs as often reported by some media platforms scares them. Experiences of violence not only increases the risks of KPs acquiring HIV but also deeply *affects their desire and ability to be tested for HIV and adhere to HIV treatment.*

3.4 Conclusions and Recommendations

The assessment on HIV prevention interventions indicate that the performance across most of the thematic areas are commendable. Further efforts should:

1. Ensure that HIV combination prevention interventions are delivered as a package across the communities.
2. Ensure that service integration is effective and programs address social-structural barriers in the design of the programs.
3. Ensure that priority prevention interventions are fully reaching those in most need.
4. There should be increased funding targeting prevention interventions to maximize the benefits.
5. Improve individual/community leadership and accountability for prevention programs.
6. The policy development and programming like the National HIV Strategic Planning, Health Sector Planning should incorporate new and emerging population groups like PWID and LGBTIQ to expand and further strengthen the response.
7. There is a need for continuous capacity building for HWs to offer KP friendly and STI management services.
8. The training curriculum for HWs and peers providing KP friendly services should be rolled out.
9. Social mobilization on HIV self-testing among KPs should be strengthened and scaled up.

3.5 CARE AND TREATMENT

This NSP (2015/16- 2019/20) puts primary emphasis on efforts that rapidly increase enrolment, better retention in chronic care, and early initiation of ART, effective HIV treatment, and greater adherence to HIV treatment. Comprehensive HIV Care Services based on a coherent continuum of care and standardized protocols remain the foundation for the ART scale-up but with intensified quality assurance, strengthened community linkages, and institutionalizing treatment and drug resistance monitoring. The NSP further focuses on overcoming the unique delivery and demand barriers especially for KPs, children, adolescents, and men in each component within the overall care continuum. These efforts guide the country towards "diagnosis of 90% of HIV infections, the achievement of 90% engagement in chronic care, treatment of 90% of eligible individuals, and suppression of viremia in 90% of treated individuals" (UAC 2018).

3.5.1. Access to ART for Adults

The assessment focused on the availability of drugs, male involvement, integrated service delivery to eliminate stigma and discrimination, competent staff in HIV comprehensive services, privacy, and outreach programs.

Table 20: Access to ART for Adults services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Access to ART for Adults services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					

	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

The results show that majority of the respondents were satisfied with ART treatment for adults. The respondents attributed good performance on the availability of drugs, well-trained health workers, testing for viral load and CD4 count, and support by facility linkage facilitators. However, it was noted that some challenges were highlighted including stigma and discrimination, low male involvement, inadequate support for community systems and linkages to support adherence and tracking patients that are lost to follow-up. Where the VHTs and Expert clients exist, they are not facilitated. In addition, non-disclosure, especially among men, was noted as an issue for access to ART.

> *As a woman living with HIV, I still fear to come for service because I will face questions from my friends and my husband. (Female Participant, Pawe HC III, Amuru District)*

> *Sometimes when you come alone, you don't get services. (Female Participant, Bwijanga HC IV, Masindi District)*

> *There is this new drug DTG that has caused a lot of stigma; there is a fear that it will stop women from producing children. (KI Health Worker, Mbale District)*

> *"The ARVs are always available and accessible and they are rarely out of stock", Nyakwae HC III, Abim District.*

"The service is available both at the facility and the community through outreaches, ARVs are ever in stock, expert clients also known as linkages do the follow-ups, there are health II drug distribution points but DTG is still offered only for the non-reproductive women and other populations, stigma and discrimination yet another issue", Balawoli HC III, Kamuli district.

"Clients can access the service. Should they miss their appointments, follow-up with phone calls is done, home delivery is done or clients send someone to pick their refills" Ikumbya HC III, Luuka District.

"ART services are available though there is a gap on adherence by the adults due to stigma and discrimination" Bugono HC III, Iganga District.

Table 21: Access to ART for Adult KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Access to ART for Adults	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

According to the results, most respondents rated treatment (access to ART) as performing very well. Respondents attributed good performance to the availability of drugs, use of new guidelines (Test and Treat), differentiated service delivery models such as Drop-in-Centers (DICs), which attract and ensure retention of KPs. However, it was noted that ART has some challenges, including stigma, health worker attitudes, and public attitude towards the KPs that creates fear among KPs, thereby affecting their adherence and retention in care.

ART is available and is given to all HIV positive persons. ART is available and never runs out of stock. (Female Participant, ST. Paul Hospital*, Kasese District)*

Sometimes, we are not informed about switching from one regimen to another, instead they just call us to sign to change regimen when viral load results come back. (KP Respondent, Lira RRH)

3.5.2 Paediatric HIV care

According to the NSP, increasing access to ART and sustaining the provision of chronic care for patients initiated on ART constitute a strategic objective, which is aimed at expanding and consolidating pediatric care in all accredited ART sites. The assessment aimed to establish whether health workers had comprehensive knowledge to handle children. It also focused on Early Infant Diagnosis (EID), community-health facility linkages, stigma and discrimination, uninterrupted supply of ARVs, existence of innovative distribution options, and available options for managing the loss to follow-up.

Table 22: Pediatric HIV care services

Variable	District	Health Facility Level

		IV	III	III	III	III
Pediatric HIV care services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					

	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The performance of pediatric HIV care was reported to be good, and this was noted to be a result of the availability of drugs, public education, counseling for mothers, and provider-initiated testing and counseling in children clinics. In addition, the integration of pediatric care in other services such as immunization has facilitated good performance. Some of the challenges associated with pediatric HIV care include loss to follow-up of the mother-infant pair, stigma and discrimination.

> *We are innovative enough to create some incentives to motivate the mothers and their children. (Health Worker Participant, Laguti HC III, Pader District)*

> *In our community, we have too much stigma faced by mothers and children living with HIV, yet these people would be giving information to our local people. As a result, this stigma prohibits them from accessing services. Besides, community and family support are inadequate especially when it comes to feeding the children living with HIV and the adolescents. (FGD, Padibe HC IV, Lamwo District)*

> *"Paediatric HIV care services are available but the community has poor health services seeking behaviours." - (Health Worker Participant, Lotome HC III, Napak District)*

> *"Follow up is very hard because there are some children who live with their relatives not parents and the care given to them is not good" Female Expert Client, Bugono HC III, Iganga District*

Participants made the following recommendations: active engagement of parents/caregivers of the children on service uptake, having specific appointment days for paediatric care, strengthening follow up mechanisms using community resource personnel/expert clients, and continuous mass education about sustaining pediatric HIV care.

3.5.3 Access to Adolescent HIV Treatment

WHO guidelines on care and treatment and adolescent's treatment (2015) define HIV treatment as services that are specifically integrated into health care services for youth health-related events. The assessment looked at youth-friendly corners, youth ART refill designated day, integrated system for ART access and sensitization, and lost follow-up mechanisms.

Table 23: Access to Adolescent HIV Treatment services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Access to Adolescent HIV Treatment	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					

	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi		-			
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents rated the performance of adolescent HIV care and treatment as good. The ranking was justified by the availability of drugs at health facilities, having specific days for youth ART refills, youth-friendly corners in some facilities, and follow up through peers. However, it was noted that there is stigma and poor adherence and drop out of care by adolescents. Besides, there is a lack of enough space for youth, which affects the privacy to serve the young people and increases their stigma and exclusion from care.

> *Youths have formed groups and one of them takes medicines to other group members. (Interface Participant, Pajule HC IV, Pader District)*
>
> *There is no conducive space for adolescents because the one we have is in the ART room. This makes adolescents uncomfortable because they think that when other people see them, they will think they are HIV positive. (Health Worker, Bukalasa HC III, Luwero District)*
>
> *Children (adolescents) are always combined with adults and there is a lot of time for the adolescents. (Female Participant, Pajule HC IV, Pader District)*
>
> *There is no youth corner and youth-friendly services - they are mixed with adults.* (Busano HC IV, Mbale District)
>
> *"The youth fear to come for refills but ARVs are available", FGD Participant, Nakapelimoru HC III, Kotido District.*
>
> *"Adolescents have dropped from treatment due to stigma", Tokora HC III, Nakapiripit District.*
>
> *"No special units are designated for youth but they access their ART services together with adults" FGD Participant, Lotome, Napak District.*
>
> *"Young people continuously are stigmatized and fear to come pick drugs when people are watching", Gudamire HC III, Kaliro District.*
>
> *"There is too much of poor attitude of the adolescent, especially I don't care attitude. Which makes it very hard for them to adhere well. There are no youth programmes at the health facility" Bugono HC III, Iganga District.*

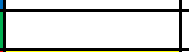
Respondents recommended that more space for young people be provided at each health facility. In addition, there is need to train health workers to provide youth-friendly services and adolescent targeted services especially during school holidays.

3.5.4 Availability of other diagnostics and medicines for HIV management

The assessment inquired about the availability of other medicines such as septrine, uninterrupted supply of OI diagnostics and medicines at the facilities.

Table 24: Availability of other diagnostics and medicines for HIV management services

Variable	District	Health Facility Level				
		IV	III	III	III	III

Availability of other diagnostics and medicines for HIV management services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					

	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results show that more than half of the respondents were satisfied with the service. This was attributed to the interrupted supply of medicines; health workers with comprehensive knowledge of managing the patients and support by Development partners beyond the district health office; and support supervision and mentorship. However, some respondents were concerned with the suspension of septrine by the Ministry of Health, which has made some patients suffer from cough and fear of early death.

> *The removal of septrine brought fear to HIV patients. (Healthcare Provider, Palebek HC III, Lamwo District)*

> *"OIs are diagnosed but there is a lot of interrupted drug supply for treatment of these complications. The patients are tested and asked to buy such drugs by themselves especially fluconazole", FGD Participant, Balawoli HC III, Kamuli District.*

3.5.5 Integrated services for HIV, TB, RMNCAH, and STIs

In line with Uganda's national policy guidelines for TB/AIDS collaborative activities (2006), collaborative services emphasizing integrating care and treatment for patients with TB/HIV, through enhancing screening for patients, routine testing and diagnosis of TB is emphasized. TB is the number one killer of PLHIV, causing more HIV related death. To improve outcomes for clients, integrating TB screening in HIV testing and treatment is essential. The respondents were asked about their knowledge of the linkage between HIV and TB, HIV services integration with a full range of FP services, and expert clients' skills in supporting the delivery of FP services. Table 24 below provide their responses.

Table 25: Provision Integrated services for HIV, TB, RMNCAH, and STIs

Variable	District	Health Facility Level				
		IV	III	III	III	III
Provision Integrated services for HIV, TB, RMNCAH, STI	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					

	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

"All services offered in this health facility are integrated", FGD Participant, Bugaya HC III, Buyende District

"Services at the health facility are integrated especially in relation with TB and HIV, linkages are done at facility and community, FP service is provided to eMTCT mothers but then the isolation rooms for TB are not available due to infrastructure limitation", FGD Participant, Bulawoli HC III, Kamuli District.

"Our services are integrated but we lack enough staff to offer them at all entry points" FGD Participant, Barakala HC III, Yumbe District.

The majority of the respondents were comfortable with services integration. They attributed the integration to the deliberate efforts by the Ministry of Health to have the services integrated, the willingness of health workers to support the integration and availability of drugs, community awareness, and provider-initiated counseling services in all disease condition clinics. However, it was noted that with the heavy workload, health workers are not able to comprehensively address the needs of all clients. The other challenges entailed limited community structures to support TB interventions, inadequate infrastructure at health centers and admission of TB patients in the same wards with other patients.

Table 26: Existence of STI interventions and Management for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Existence of STI interventions and Management for KPs and vulnerable groups	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

Participants reported that STI interventions and management were good, while is some other places, they were average. They noted that KPs were tested for HIV and diagnosed for STIs whenever health workers mobilized them for outreaches or whenever some went for services at the health facilities.

3.5.6 Availability of Viral load monitoring services

HIV treatment and disease burden monitoring and management require CD4 count and viral load assessment to monitor the clients' adherence to HIV treatment and viral suppression. The inquiry focused on the availability and accessibility of CD4 count testing services in ART accredited health facilities, and turnaround time for viral load results to support optimal treatment outcomes.

Table 27: Availability of Viral load monitoring services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Viral load monitoring services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					

	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The majority of the respondents ranked the performance of the services as good. This ranking was attributed to short time turnover for CD4 and Viral load results in health facilities, improved hub system in the districts, and follow-up calls to clients when their results were ready. However, the respondents reported that stock out of reagents, long-distances that clients move to access the services remain some of the challenges to the service delivery.

> *"The services are available, the clients are sensitised, there is a committee that ensures VL suppression, VL is done timely but because the facility doesn't have a hub results most of the times doesn't return timely"* Bulawoli *HC III, Kamuli District.*

"Viral Load monitoring is handled well and timely. Client files are labelled for proper VL monitoring", FGD Participant, Lukolo HC III, Jinja District.

"Sometimes results take longer to come out. Some results get lost in every bunch that is being sent to the referrals hospital for check-up", FGD Participants, *Bugono HC IV, Iganga District.*

Table 28 Availability of Viral load monitoring services for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of Viral load monitoring services	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The assessment results indicated that the majority of the respondents ranked the performance of the services as good and this was attributed to the short turnaround time for Viral load results in health facilities, improved hub system in the district, cluster/grouping model, and Peer system that facilitates follow-up calls to clients when their results are ready. However, long-distances moved by clients to access the services was highlighted as a major challenge.

3.5.7 Mechanisms for community-level follow-up and treatment support for adults and children living with HIV

The study assessed available community-based mechanisms for follow-up and support to people living with HIV and any challenges that affect these mechanisms.

Table 29: Mechanisms for community-level follow-up and treatment support for adults and children living with HIV

Variable	District	Health Facility Level				
		IV	III	III	III	III
Mechanisms for community-level follow-up and treatment support for adult and children PLHIV	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					

	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents ranked the availability and performance of the community-based mechanisms for follow-up and support for people living with HIV as average, while others ranked it 'very good'. They attributed this to the existence of active Networks of People living with HIV, expert clients, and VHTs who follow up people on treatment. The support provided by linkage facilitators, peer educators and friends of young people were mentioned as key in the performance of the intervention.

However, respondents were concerned with the lack of funds to transport the poorly motivated VHTs and expert clients and poorly resourced networks of PLHIV and KPs. Key recommendations included the need for training in home-based care services, facilitation, and motivation of community resource persons such as expert clients and linkage facilitators to enable them to provide home-based services.

> *We now use location follow-up mechanisms other than relying on phone calls; sometimes, clients give us the wrong phone number. (Health Worker, Katikamu HCIII, Luwero District)*
>
> *"The linkage facilitators and health workers move to communities to follow up clients", FGD Participant, Akunalaber HC III, Kitgum District.*
>
> *"Airtime, bikes, phones, umbrellas, transport facilitation, uniforms should be given to VHTs, mentor mothers and CMM to motivate them access hard to reach communities" FGD Participant, Mayuge HC III, Bugiri District.*
>
> *"We do have VHTs who do follow-ups however they are not well facilitated to do their work", FGD Participant, Butama HC III, Bundibugyo* ***District.***

3.5.8 Availability of supplementary food at HIV care and treatment sites

The assessment asked about whether the people who come for HIV care and treatment were given supplementary foods.

Table 30: Availability of supplementary food at HIV care and treatment sites

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of supplementary food at HIV care and treatment sites	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					

Variable	District	Health Facility Level				
		IV	III	III	III	III
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					

Source: Field Data

Most of the respondents were not satisfied with the services because no food is supplied to patients at the facilities. However, they noted that during the health talks, they were sensitized on nutrition and dieting in order to boost their immunity.

3.6 Conclusion and Recommendations

- Provide more space to cater for young people at each health facility.
- Train health workers in the provision of youth-friendly services.
- Establish linkages between the school system and health facilities to create a safe and supportive. environment for young people living with HIV.
- Conduct adolescent targeted services, especially during school holidays.
- Address infrastructural needs at health centers to ensure that admission of TB patients in the same wards with other patients is eliminated.
- Support community structures to support TB interventions.
- Conduct training in home-based care services.
- Support facilitation and motivation of community resource persons such as expert clients and linkage facilitators to enable them provide home-based services.
- Scale-up interventions to eliminate stigma and other forms of discrimination for KPs and PLHIV.
- Support stigma index study among key populations.
- Ensure continuous engagement with legal and enforcement sectors as key stakeholders in KPs response.

3.7 SOCIAL SUPPORT AND PROTECTION

According to the National HIV&AIDS Strategic Plan (2015/16- 2019/20), social support and protection is aimed at reducing the vulnerability to HIV&AIDS and mitigating its impact on people living with HIV and other vulnerable groups. By scaling up the strategies for eliminating stigma and discrimination, mainstreaming development programs in all relevant sectors and life cycle comprehensive package; social support and protection interventions for PLHIV are crucial and critical. Therefore, the assessment looked at the quality of psychosocial support services, rights awareness and support, availability of legal support and social services, the existence of sexual and gender-based violence, awareness and availability of PEP and emergency contraceptives, the existence of skilled service providers in GBV/SGBV and functionality of referral system for SGBV cases.

3.7.1 Rights awareness and Support

The Uganda Patients Charter of 2009 describes a set of rights, responsibilities, and duties under which a person can seek and receive health care services, empowers patients to responsibly demand quality health care and actively participate in their care at health facilities. The assessment inquired about awareness of existing laws on HIV and health, availability of interventions to popularize the existing bad or good laws concerning health and HIV&AIDS. It also examined the enforcement of relevant laws and policies to ensure human rights and fundamental freedoms of PLHIV, OVC, KPs and other vulnerable populations and engagement of cultural leaders to address cultural norms, practices, and attitudes.

Table 31: Rights awareness and support

Variable	District	Health Facility Level				
		IV	III	III	III	III
Rights awareness & Support	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					

	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The ranking for this thematic area was majorly poor and very poor. Respondents attributed their ranking to inadequate IEC materials and limited number of implementing partners focusing on legal awareness while linking it to HIV&AIDS interventions. Therefore, they recommended sensitization about rights and responsibilities through seminars, involving local and cultural leaders, holding community dialogues, and translating materials and disseminating them in local languages.

> *"We are not aware of the laws but for the rights we know" FGD Participant, Karita HC III, Amudat District*

> *"The health rights charter is available in the facility and it's translated into the local language, but awareness levels are still low", FGD Participant, Namalu HC III, Nakapiripit District*

> *"There is knowledge gap at all level when it comes to this service, both at the community and the facility level" FGD Participant, Balawoli HC IV, Kamuli District.*

3.7.2 Availability of legal support and social services

The assessment focused on the existence of trained community-based paralegals to carry out community education campaigns on human rights, legal and ethical needs of PLHIV, OVC, KPs and other vulnerable populations. It also examined the provision of testing services and legal support/representations in courts of law for cross-examination and witnessing, and community sensitization on seeking legal services in care assault and filling of police forms to support the victims. The other aspects included stigma and discrimination; follow-up on cases in courts of law; existence of messages to address stigma experienced in homes, communities and other institutions such as schools, hospitals, workplaces and places of worship.

Table 32: Availability of legal support and social services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of legal support and social services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					

	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results show that the majority ranked legal support interventions as average and good. On the other hand, some respondents reported the service as poor and very poor. This was attributed to the community not seeking legal support from police, high levels of stigma and discrimination, lack of transport to follow up cases, long court processes, and inadequate knowledge in the community to seek legal redress whenever their rights are abused. However, there was the existence of referral mechanisms by service providers to the police for those that faced gross human rights abuse.

> *"There are no official systems in place; the ones available are community courts, elders' courts that are sometimes not supportive and offer the justice required" FGD Participant, Nyakwae HC III, Abim District.*

> *"GBV cases are there and they are handled by CDO though sometimes due to corruption these issues are not handled fairly", FGD Participants, Bumanya HC IV, Jinja District.*

3.7.3 Sexual and Gender-Based Violence

The assessment sought to establish whether SGBV was a common occurrence and availability of context-specific interventions that address harmful socio-cultural and gender norms.

Table 33: Sexual and Gender-Based Violence

Variable	District	Health Facility Level				
		IV	III	III	III	III
Sexual and Gender-based Violence	Tororo					
	Mbale					
	Bukwo					
	Kole					

	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Some respondents perceived SGBV services as average while others as good. The rankings are attributed to trained staff by some local NGOs, the existence of the relevant local authorities including police and Local Councils, and established functional referral mechanisms for victims to health facilities by police or from health facilities to police. However, the lack of community sensitization programs for SGBV was given as one of the critical concerns. Reporting of SGBV cases is still a challenge in many districts due to several social, economic, structural and institutional challenges and there were also high levels of a culture that normalizes violence against women, girls and children that affects the community, law enforcement, and health services responses. In addition, victims fear to seek justice especially where the perpetrators are intimate partners/ spouses, while poverty among women makes it quite costly to seek justice. Another challenge is associated with the slow pace of court and legal recourse that leads to loss of interest in cases and long distances between communities and health facilities. Men's awareness of women's rights and their involvement in GBV interventions is limited in scope, which affects their active involvement as change agents. Traditional gender stereotypes of exercise of power and control over women by men still prevail. For example, some women have accepted *'wife-beating as part of life, marriage, and love'*. The existence of norms and customs such as dowry and bride price that render women as the property of men. They cannot control their lives and bodies; hence, they become more vulnerable to SGBV. These practices are still an obstacle to fighting GBV because it is often normalized; redress mechanisms are easily available to the victims and survivors of SGBV. Lastly, alcohol and substance abuse have also been cited as one of the drivers of high rates of violence against women, girls, and children.

> *GBV is very common in our communities due to alcoholism; here, people take too much alcohol. (HUMIC Member, Aboke HC IV, Kole District*

> *GBV is rampant on the islands due to their lifestyle of heavy drinking and a kind of loose lifestyle. Here, both men and women are violated. Men and women fight; it is not an issue of one sex dominating but all of them fight in equal measures. (Female Respondent, Namatale HC III, Buvuma District)*

> ***"****GBV is very common in our communities due to alcoholism, people here take too much alcohol" - (FGD Participant, Lorengechora HC III, Napak, District*

> *"Cases of sexual gender-based violence exist e.g. some husbands don't want to use condoms and when women resist, they are beaten up" FGD Participant, Butama HC III, Bundibugyo District.*

3.7.4 Availability of PEP and emergency contraceptives

Table 34: Availability of PEP and emergency contraceptives

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of PEP and emergency contraceptives	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					

	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The respondents perceived PEP kits and emergency contraceptives services in facilities as average and good because some facilities are accredited to offer PEP services and the integration of HIV and FP services. However, more awareness about the existence of PEP services needs to be integrated into health education component at FP clinics.

> *"They are available and women and girls who are raped are examined and treated at this facility", FGD Participant, Nyakwae HC III, Abim District.*

> *"The PEP services are available but not known to the clients and there is not enough supply of emergency contraceptives", FGD Participant Balawoli HC III, Kamuli District.*

> *"PEP kits are available though most people don't make use of PEP because of fear and misconceptions. There are contraceptives though they are not enough and people know do not that they do exist" FGD Participant, Bugono HC IV, Iganga District*

3.7.5 Service providers skilled and trained in GBV/SGBV management

Table 35: Availability of Service providers skilled and trained in GBV/SGBV management

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of PEP and emergency contraceptives	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					

	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results indicated that there are trained service providers to offer SGBV services in the community. The participants also reported that they were not aware of trained persons and where they are located. Health workers also noted that there were very few trained workers among themselves; they recommended having more health workers oriented on delivery of SGBV services.

> *"We have a health worker who is ready to help but at times these case end at village level with negotiations", FGD Participant, Orwamuge HC III, Abim District.*

> *"There is a trained health worker who registers and follows up on GBV/SGBV cases", FGD Participant, Nankoma HC IV, Bugiri District.*

> *"Two health workers were trained but no tools were provided and they are busy with maternity work", FGD Participant, Kathile HC III, Kaabong District.*

3.7.6 Availability of functional referral system for SGBV cases

Assessment inquired about the availability of quick response when SGBV is reported to relevant authorities.

Table 36: Availability of a functional referral system for SGBV cases

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of PEP and emergency contraceptives	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					

	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field data

Most of the respondents reported that the services were "poor" and "very poor". Participants attributed the performance to lack of quick response when SGBV is reported to relevant authorities and poor awareness in the community about any existing systems of redress in the case of SGBV.

> *"We have the committee of women and LCs and the police are also very active in handling SGBV issues, however, they are not well conversant with them"*
>
> *"The referral pathways are functional because we have been receiving referrals from community by VHTs, LC1 and police and we also refer to the police" FGD Participant, Kotido* HC IV, *Kotido District.*
>
> *"Even if people report, sometimes the police don't take it up because they want money and, in that case, they do not attend to you", KI Respondent, Bundibugyo District.*

3.7.7 Enablers and barriers to accessing services by KPs

Furthermore, the assessment focused on finding out the enablers and potential barriers to accessing the services by Key Populations. Therefore, attitudes of health workers towards Key Populations and discrimination and marginalization of KPs were considered.

Table 37: Health workers and community attitudes towards KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Unfriendly health workers and community	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The assessment shows that most respondents believed that service providers and community attitudes are not friendly to KPs because of the religious, socio-cultural, and gender-based norms, values and stereotypes. These attitudes contribute to varying levels of disapproval, exclusion, and even persecution of persons and groups associated with these identities, orientations, and behaviors. Participants noted that in some health care settings, the environment translates into judgmental attitudes, hostility, labelling, and discrimination in

the delivery of services. Consequently, specific groups such as MSM, Transgender persons, and SWs have difficulty in trusting that health care workers will not disclose their identity, which leads them to delay or avoid seeking care for sexuality-related issues. This affects adherence to care and retention in services.

> *Some health workers hide our files on realizing you're a KP and you end up waiting from morning to evening. (KP Participant, Lira RRH, Lira District)*

> *Others [health care workers] have studied only for money and have good 'morals' but don't want to help people. The [negative] attitude exists; when KPs come, you hear health workers say, 'you go around messing, when you're sick, you come here'. In addition, some health workers don't know about the service. (Health Worker Participant, Lira District)*

Table 38: Discrimination and Marginalization of KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Discrimination and marginalization	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

Respondents reported that there was discrimination against KPs. Respondents attributed this to prejudice. Some service providers are generally uncomfortable with sexual orientation/diversity. They have little understanding of the dynamics of the diverse sexual orientations and identities and their implications on health and wellness. It was noted that even within the public, there was limited understanding of or empathy for the depression, anxiety, mental health, and other psychosocial issues that members of sexual minority groups often struggle with.

> *As a street-based sex worker, I have to hide my identity for fear of being identified as a sex worker because of community perceptions. Accessing sexual health services is often affected by the fear of being identified as a sex worker. (Sex Worker, Kasese District)*

3.7.8 Recommendations: Social Support and Protection

1. Support to CBOs to implement community awareness about social protection and anti-stigma interventions.
2. Support scale-up of legal support services to enhance the rights of PLHIV, KPs, and other vulnerable populations.
3. Develop a public campaign to promote the involvement of men in SRHR, HIV, and GBV elimination interventions.
4. Support to scale up comprehensive SGBV support services to enhance rights and redress mechanisms for women living with HIV, sex workers, women who inject and use drugs when they are violated. These services would include psychosocial support, post-rape interventions, legal support, provision of health

support (tests, PEP, emergency contraception, etc.) and information access to ensure demand generation for the services.

CHAPTER FOUR – TUBERCULOSIS

4.0 Introduction

Tuberculosis (TB) is one of the main causes of illness and death globally, accounting for an estimated 8.8 million new cases and 1.6 million deaths per year. In Uganda, TB remains a major public health problem, making the country one of the 22 high burden TB countries in the world that contribute to 80% of the global TB burden (WHO, 2016 global TB report). Therefore, the assessment sought to establish the availability and performance of TB related services in the districts.

4.1 Availability of qualified staff to screen and diagnose TB

The assessment focused on availability of TB diagnostics and treatment guidelines, the standard operating procedures, knowledge about available TB services at the facility by the community, and processes that beneficiaries go through. It also looked into training and facility mentorships for health workers in the management of TB disease focusing on the diagnosis of clinical, EP-TB and childhood TB. Finally, it sought to establish availability of standardized data collection tools for TB management including their use and capacity of health workers to screen and diagnose TB focusing on childhood, extra-pulmonary and clinically diagnosed TB.

Table 39: Availability of qualified staff for TB Management

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of qualified Staff to treat TB	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					

	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum	`				
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results indicated that most of the respondents were satisfied with the available services and availability of qualified staff to manage TB cases given the capacity building opportunities for health workers, onsite mentorships, technical support supervisions, coaching, and offsite training. Participants reported that regular supervision of TB focal persons has helped to improve their capacity to provide better care to people with TB, hence the improved rates of treatment. Participants also stated that healthcare providers give people with TB priority because they receive services before other patients. It was also reported that healthcare providers generally have positive attitudes towards people with TB and TB care. However, they observed that lack of motivation to health workers and TB focal person still affect the TB program performance.

> *TB is now liked and respected; we appreciate that someone has TB and we don't treat them like before when TB was taken as a disease for people who are not hygienic and were blamed. [Today] when they come for drugs, they are given a priority; when they are coughing, they are supported. (KI, Nakaseke District)*

District Health Team members regularly come around for technical support supervision, especially the District TB and Leprosy Supervisor. (KI, Mulanda HCIV, *Tororo District)*

Health workers care about TB patients and they are given masks to cover their noses. (Female Respondent, Butiaba HC III, Bulisa District)

"Our health workers are well trained to screen and diagnose the sputum. Sputum is carefully taken to Abim hospital and results always come back after two days" FGD Participant, Nyakwae HC III, Abim District,

"TB, the best department in the facility with 5 dedicated staff", FGD Participant, Gadumire HC III, Kaliro District.

"The staff at the laboratory is knowledgeable in diagnosis and other health workers know how to screen for TB" Nabisoigi HCIII, Namutumba, District.

The participants recommended that to achieve better TB treatment outcomes, CQI and staff be motivated through facilitating the focal persons, mentorship, supervision, and training of health workers be undertaken by the district Health team and Ministry of Health.

Table 40: Availability of qualified staff to screen and diagnose TB for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
LLINS accessible and available especially for pregnant women and children	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The results show that most respondents were satisfied with the services because of trained staff, mentorship offered to the staff, and availability of equipment.

4.2 Integration of TB care and prevention into other healthcare service delivery interventions

The assessment considered the following: availability of TB care and prevention services, TB integration into other healthcare service delivery interventions, availability of isoniazid preventive therapy (IPT) to contacts of the under-five year-olds new PBC cases, and existence of TB care and prevention.

Table 41: Integration of TB care and prevention into other healthcare service delivery interventions

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Integration of	Tororo					

TB care and prevention into other healthcare service delivery interventions	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					

	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents rated the services good and very good because of the coaching and mentorship by implementing partners to strengthen the integration of TB/HIV services using the one-stop-shop model, targeting the poorly performing health facilities in the districts. The other reasons included patient retention by strengthening appointment keeping, cohort monitoring and follow up of TB patients with unfavorable treatment outcomes by community linkage facilitators (CLFs). They further reported that the policy on TB/HIV collaborative policy guidelines has facilitated the implementation of TB care and prevention into other services.

> *"TB fully integrated as there is no special day for handling TB clients. They are immediately attended to as and when they come in. Also treated as an emergency to avoid spreading infections", FGD Health worker participant, Kidera HC IV, Kamuli District.*

> *"TB care and prevention services are integrated and given to people. For those who have been imprisoned are also given health services every week; where they are tested and results are given to them those found positive are given treatment", Bumanya, HC IV, Kaliro District.*

Table 42: TB care and prevention integration in other healthcare service delivery interventions for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
TB care and prevention integrated into other healthcare service delivery interventions	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The results show that most respondents were satisfied with the TB care and prevention integration in health care services at health delivery points across all the four districts. The participants attributed this performance to policy on TB/HIV collaborative policy guidelines, which have facilitated the implementation of TB care and prevention into other services and health workers' skills.

4.3 Availability of TB screening and testing equipment

This study assessed the availability and utilization of TB diagnostics (Xpert MTB/Rif, FM/ZN microscopy, LAM, sample collection, and referral system), culture & DST, and second-line LPA.

Table 43: Availability of TB screening and testing equipment

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of	Tororo					

TB screening and testing equipment	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					

	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The above performance was attributed to the availability of screening and GeneXpert utilization. In particular, health workers noted that there has been a deliberate effort by the Ministry of Health to ensure that all facilities that provide TB prevention and treatment services have the equipment.

Despite the good performance, several challenges persisted, including low availability of X-ray services in most public health facilities. For instance, some X-ray machines are either broken down, have inadequate supplies/deficiencies in the supply of reagents-cartridges that lead to stock-outs at various testing points. The ones available in the private sector were not affordable to most people. In addition, participants noted that there were no personnel to operate the available equipment coupled with staff transfers, thus affecting continuity of service delivery.

Table 44: Availability of TB screening and testing equipment for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of TB screening and testing equipment	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The results above show that majority of the participants were satisfied with the services. The performance was attributed to the availability of screening and GeneXpert utilization by patients. In particular, the health workers noted that there had been a deliberate effort by the Ministry of Health to ensure that all facilities that provide TB prevention and treatment services had the equipment.

4.4 Availability of facility - community linkages for TB

The assessment focused on the availability of facility and community health systems to facilitate referral of presumptive TB patients to diagnostic facilities. It also considered support treatment adherence and systematic TB screening among contacts (CHEWs, CLFs, and VHTs) about the utilization of community linkages and linkage tools at the health facilities and community levels.

Table 45: Availability of facility - community linkages for TB

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of facility -	Tororo					

community linkages for TB	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					

	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents noted that VHTs were commonly used to quickly trace and link people with TB who are lost to follow-up back into care. It was noted that VHTs volunteered to work despite the absence of financial incentives because TB focal persons continually engaged them in activities of the health facilities. Therefore, the results support the important role played by VHTs in following up people on long term treatments. However, it was noted that VHTs faced financial constraints in undertaking their roles to reach out to more clients. It was recommended that although VHTs proved useful in TB care, strong coordination, leadership, and motivation are needed to get the best results.

> *"The presence of the cough monitors both at the facility and community level is successful" Bulawoli HC III Kamuli District.*
>
> *"Linkage facilitators, VHTs and neighbours are doing a great job" Ikumbya HC III, Luka District.*
>
> *"Most clients are not willing to be followed up due to stigma" FGD Participant, Lukolo, HC III, Jinja District.*
>
> *"Contact tracing and treatment support for TB patients is a challenge due to lack of funding to facilitate VHTs and linkage facilitators" KI respondent, Nabisoga HC III, Namutumba Districts.*

Table 46: Availability of facility-community linkages for TB for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of facility community linkages for TB	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

The assessment didn't show anything different from what I reported up for the general public. To note however is that participants at three health facilities ranked the services as "very poor" because of poor attitudes of health workers and some VHTs towards KPs; consequently, they fear to come for services.

4.5 Availability of IPT services among PLHIV to those without TB

During the assessment, the inquiry was done on health workers' capacity to diagnose TB using symptom screenings and CXR, availability of IPT services among PLHIV to those without active TB disease and health workers trained on TB/HIV and ART management emphasizing MDR/RR-TB treatment sites for the general population and among KPs.

Table 47: Availability of IPT services among PLHIV to those without TB

Variable	District	Health Facility Level

		IV	III	III	III	III
Availability of IPT services among PLHIV to those without TB	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					

	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents attributed the high ranking to health workers' capacity to diagnose TB using symptom screenings. Participants noted that the majority of health workers were knowledgeable about isoniazid preventive therapy (IPT) as part of a package of care for PLHIV. However, it was reported that there were low IPT completion rates attributed to insufficient stocks. The reasons were reportedly the same among the participants from the general population and key populations.

Table 48: Availability of IPT services among PLHIV to those without TB for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of IPT services among PLHIV to those without TB	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

4.6 Availability of TB/HIV interventions for PLHIV

The assessment focused on: intensified case finding for TB among PLHIV, engagement of the beneficiaries in the roll-out, availability of TB/HIV interventions to decrease the burden of HIV among patients with presumptive and diagnosed TB and availability of TB/HIV treatment guidelines.

Table 49: Availability of TB/HIV interventions for PLHIV

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of TB/HIV interventions for PLHIV	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					

	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents justified their above scores with the following reasons: patients' knowledge on infection control measures during health talks and HIV clinic days at most health facilities, psychosocial support such as counselling and sharing through the encouragement of community support groups, treatment adherence education for both TB and HIV treatment and monitoring of adverse effects. The assessment also found out that there is institutionalization of TB management at most facilities where most interventions are beyond

the TB focal person. It was also noted that the in-charges of health facilities, namely the health assistants, laboratory personnel, community linkage facilitators, and VHTs were involved in contact tracing with each one playing different roles. This represented a change from traditional TB programming where all TB work was left to specialized TB health workers.

> *TB is no longer the work of TB Focal Person to ensure TB case notification or mass education at our facility but a job for everybody. We have to ensure full integration and hence everybody is involved. (Health Worker, Semuto HCIV, Nakaseke District)*

It was further noted that there has been TB integration in community outreaches for HIV counselling and testing, immunization, cervical cancer screening, deworming, and antenatal care.

Table 50: Availability of TB/HIV interventions for PLHIV under KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of TB/HIV interventions for PLHIV	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

Results on the availability of TB/HIV interventions for PLHIV at health facilities show that most of the respondents were happy with the services because health workers have patients' education on infection control measures during health talks and HIV clinic days at most health facilities. There is also psychosocial support, such as counselling and sharing through the encouragement of community support groups, treatment adherence education for both TB and HIV treatment and monitoring of adverse effects.

> *"People who are infected by TB and HIV are enrolled on TB programs at this facility and the TB-HIV Interventions are integrated" FGD Participant, Nyakwae HC III, Abim District.*

> *"Every PLHIV is monitored for TB and educated on relationship of TB/HIV", FGD Participant, Kiyunga HC IV, Luuka District.*

> *"The PLHIV are given INH and all Education talks for PLHIV include TB as a topic of discussion" FGD Participant, Nambale HC III, Iganga District.*

4.7 Conclusions and Recommendations

The community scorecard results indicate that TB program was performing well and this was attributed to the deliberate efforts by the government to ensure TB is integrated into other health care programs. Furthermore, investment by partners in HIV/TB collaborative interventions has facilitated the performance of the program. However, some challenges ranging from systems such as limited infrastructure at the facility level, including limited human resources and logistics to inadequate support to community systems to complement public health facilities were noted. Traveling of long distances to health services by patients

and lack of money were other obstacles to the treatment and adherence to TB management. Others included inadequate linkages with private practitioners, hospitals, laboratories, or NGO services.

4.8 Recommendations:

1. Support community systems strengthening through CSOs/CBOs to improve public knowledge/literacy about TB aimed at reducing stigma and discrimination and improving adherence to TB treatment. The barrier of fear of being isolated should be addressed by intensifying sensitization to increase awareness and emphasize the importance of seeking TB care and treatment services. This can be done via social media campaigns with advocacy messages and success stories.

2. Develop an advocacy plan aimed at mobilizing public and policymakers towards prioritizing TB interventions at various levels.

3. The Ministry of Health TB program should continue to invest time and resources in continuous improvement of regular support supervision, capacity building of health workers, and prioritizing better management of people with TB.

4. Consider an investment in the decentralization of TB/HIV services at the lower-level facilities; for example, use of outreach and differentiated service delivery models through community-based structures such as VHTs, TB patient groups, CSOs, and CHEWS. Reach out to non-traditional vulnerable populations like fishing communities.

5. Consider a motivation plan for TB focal persons at health facilities and increased staff to focus on TB.

6. Increase investment in the infrastructure for all facilities to provide adequate accommodation for TB inpatients.

CHAPTER FIVE: MALARIA SERVICES

5.1 Use of Mosquito nets

Malaria is one of the leading causes of morbidity and mortality in Uganda. The Government of Uganda and Development Partners have injected large sums of money into the procurement and distribution of Long-Lasting Insecticide Treated Nets (LLIN) as a means of reducing the spread of malaria. Therefore, the community scorecard collected information about the use of LLINs in malaria prevention at the household level, mass education for utilization of LLIN, promotion of net retention, provision of IEC materials for LLIN care and repair, and larva control management.

Table 51: Access and Availability of LLINs for pregnant Women

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Access and availability of LLINs for pregnant women	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					

	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The assessment results show that respondents were satisfied with the use of long-lasting insecticide nets (LLINs) in malaria prevention in the household. The respondents attributed this to availability of the nets; mass campaigns; and routine distribution through ANC, schools, private providers, and commercial outlets. They further mentioned that behavioral change communication interventions for LLINs use and maintenance at households contributed to the successful use of LLINs.

It was also noted that some families were using LLINs due to none preference of the white and rectangular shape LLINs. Other obstacles included unavailability of enough LLIN for the household members, use of the fireplace and sharing the same room with domestic animals. There was also undermining the extent of malaria problem, low perception on malaria prevention using mosquito nets, and using the nets for other purposes other than for the intended purpose such as for covering of household properties.

> *Basing on the people's income in this village, very few can afford to prevent malaria because they do not have money to buy mosquito nets or screens for their windows and ventilators, even when they know such good practices would help their families*. (Male Participant, Bumasikye HCIII, Mbale District)

> *We received mosquito nets from the Government. However, they were given to only households with children under 5 years and pregnant women. Not all households that had children or pregnant women received these nets*. (Female Respondent, Katunguru HC III, Rubirizi District)

It was therefore recommended that health education and awareness about the benefit of continuous use of LLIN should not be limited to only high-risk groups but all household members to achieve the impact of this intervention at the community level. Bottom-up distribution of additional LLINs is required where initial

coverage is not achieved as per the revised norm of one net per two persons because the key reason for non-use of nets remains lack of access to LLINs. This underscores the importance of mass distributions to achieving universal coverage at the household level, not just overall coverage.

For key populations, they argued that some KPs cannot access LLINs because getting them, they have to be registered with village LCs and VHTs and yet most of them are in hiding due to community attitudes towards KPs.

> *How do you expect me to access the mosquito nets, supplied by the government when I am required to register with my village LCs, who discriminate against me because I am a sex worker? (Sex Worker, Lira District)*
>
> *Mosquito nets that were supplied by government are worn out. (Busia HC IV, Busia District)*

Table 52: LLINS accessibility and availability among KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
LLINS accessible and available especially for pregnant women and children	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

5.2 Household Indoor Residue Spraying (IRS)

The assessment inquired about Household Indoor Residue Spraying (IRS) that was conducted in some districts of Northern Uganda.

Table 53: Household Indoor Residue Spraying

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Household Indoor Residue Spraying	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					

	Bugiri					
	Namutumba					
	Kitgum					

Source: Field Data

Of the 33 FGDs that were held, 11 reported the service being "good" while the rest indicated that the services were "very poor". For those that reported that the services were good, mentioned that sensitization and mobilization of all relevant stakeholders, including the community and local leaders for the interventions were being handled well by the program implementers.

> *At the onset, there was mobilization and advising people on how the interventions were to be conducted. So, if people were not sensitized, this intervention would not have been a success. If you want to do anything, you must tell the person its advantages and disadvantages. When people understand that, it is very easy for them to accept.* (HUMIC Chairman, Agwata HC III, Dokolo District)

For Indoor Residue Spraying (IRS) specifically, the respondents noted that the community mobilizers went to their households ahead of the spraying team, telling people to move their belongings out of the houses before the spraying team arrived. Furthermore, respondents from FGDs cited several community factors that supported the interventions, such as local involvement of key influencers including the local leaders. For example, members of the village health team helped with the follow-up of participants during the exercise by visiting homes to ensure adherence.

> *The local leadership and government should take a step in educating its people because that is their role. Secondly, religious leaders should also pass on this information. It is the responsibility of these leaders to educate their people. (Male Respondent, Okwongo HCIII, Otuke District)*

For those that ranked the performance of the services as "very poor", reported that there were instances of misinformation regarding the intervention mainly from community individuals who did not understand the interventions or had opposing views to either IRS, household inconvenience during IRS implementation and smell of the drugs used.

> *People were complaining about the smell of the drug that was used for spraying houses because it was causing uneasiness, others say it caused vomiting.* (Female FGD Respondent, Atiak HCIV, Amuru District)

5.3 Availability of trained and skilled health workers in malaria diagnosis and treatment

We inquired about capacity building for health workers in malaria diagnosis and treatment through regular training and clinical audits in the public sectors including malaria in pregnancy development. The assessment also sought to know the dissemination of case management guidelines, policies and job aids, strengthening of the quality assurance and quality control of laboratory diagnosis element, availability of ICCM guidelines, manuals and job aids, and availability malaria prevention and treatment in pregnancy and pregnant women accessing IPT during pregnancy

Table 54: Availability of Trained and Skilled health workers

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Trained and Skilled health workers	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					

	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results indicate that most of the respondents were comfortable with the service and attributing it to the availability of trained and skilled health workers. Besides, it was noted that working with the district health teams, the Ministry rolled out the support to Health workers at HC II and III levels. The training further enhanced the provision of policies and job aids, strengthening the quality assurance and quality control of laboratory diagnosis elements, availability of ICCM guidelines, manuals, and job aids. However, workload was affecting effective delivery of services with limited time to strengthening the capacity of VHTs at the community level through training and providing an adequate stock of antimalarial drugs.

5.4 Availability of SBCC Materials for Malaria case management

Table 55: Availability of SBCC Materials for Malaria case management

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of SBCC Materials	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					

	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results indicate that about three-quarters of the respondents were satisfied with the service among the general population. The majority ranked the availability of SBCC as "very good" and "good", respectively. Respondents justified the ranking due to media campaigns on radios and print materials translated in local languages at health facilities and in the community. Key Population respondents were however not satisfied with the services because of lack of materials in some communities and those sensitive to their needs.

> *"Enough health education is given both at facility and community level" FGD Participant, Namwendwa HC IV, Kamuli District.*

> *"Mass community trainings have been done by malaria Consortium and posters on malaria are available in the facility but inadequate" FGD Participant, Loroo HC III, Amudat District.*

Table 56: Availability of SBCC Materials for Malaria case management and KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III

Availability of SBCC Materials for Malaria case management	Lira					
	Wakiso					
	Kasese					
	Busia					

Source: Field Data

5.5 Quality of VHT services in relation to malaria community case management

Table 57 Quality of VHT Services

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Quality of VHT Services on Malaria Case Management	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					

	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Most participants were satisfied with the involvement and performance of VHTs across the districts. This was attributed to VHTs' availability in the community and their dedication. However, it was noted that some people in the communities were not aware of whether VHTs had malaria medicine all the time and did not have contacts of VHTs. In addition, the number of VHTs distributing malaria medicine in the community was found to be insufficient. Some KPs argued that because of public attitudes towards them, there has been no access to the VHT services. They suggested that when choosing VHTs, some KP sensitive VHTs should be selected.

> *"VHTs are working well but they are inadequately trained and facilitated and some drug shortages usually occur" FGD Participant, Lotome HC III, Napak District.*

> *"They do a tremendous job because they supply medication to-hard-to reach communities. Supplies like coartem, ORS, panadol but run out stock" FGD Participant, Kidera HC IV, Buyende District.*

> *"VHTs were trained a long time ago and so some don't know the new treatment and diagnosis of malaria" FGD Participant, Nyahuka HC IV, Bundibugyo District.*

Table 58: Quality of VHT services in relation to malaria community Case management for KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Quality of VHT services in relation to malaria Community Case	Lira					
	Wakiso					
	Kasese					

	Busia					

Source: Field Data

5.6 Availability of ACTs for Malaria Case Management at the health facility

The assessment further inquired about uninterrupted distribution of ACTs, rectal Artesunate and Artesunate injections and relevant consumables and availability of malaria diagnostic tools (RDTs and Microscopy)

Table 59: Availability of ACTs for Malaria Case Management

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of ACTs for Malaria Case Management	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					

	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results from the assessment show that more than 2/3 of the participants were satisfied with the availability of ACTs for Malaria Case Management at the health facility. They attributed this to the uninterrupted distribution of ACTs at facilities but also through VHTs at the community level. In addition, it was noted that the Ministry of Health's redistribution Malaria Commodities from facilities with overstocks to those that are facing a stock out had boosted stocks at some facilities. However, participants noted that sometimes VHTs run out of the commodities at the community level and because they lack transport to health facilities, it takes them time to come for a refill and hence stock-outs at the community level.

> *We have only four Government trained VHTs for the whole village. However, among the four only two of these VHTs were given malaria drugs for use by children. Due to the many malaria cases among children, this medicine is usually used up in a short time leaving no medicine with these community health workers for long periods. (Male Participant, Karugutu HCIV, Ntoroko District)*

> *"The service is available but quite often these medicines are out of stock which makes clients go without or asked to buy from private drug shops" FGD Participant, Barakala, HC III, Yumbe District."*

> *"ACTs are available at the facility but sometimes experience stock-outs and delay in supply" FGD Participant, Kopoth HC III, Kaabog District.*

> *"Some facilities are experiencing stock-outs of ACTs for the whole of this financial year" KI Respondent, Bundibugyo District."*

Table 60: ACTs availability for Malaria case management and KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Availability of ACTs for Malaria case management	Lira					
	Wakiso					

	Kasese					
	Busia					

Source: Field Data

5.7 Conclusions and Recommendations

The assessment established that malaria interventions were performing well particularly with LLINs. This high-ranking performance was attributed to the Ministry of Health's extensive campaign on increasing awareness and use of LLINs in recent years, including free distribution to vulnerable groups. However, beyond the LLINs provided by the Government, many families could not afford them. Furthermore, there was a misuse of received nets including being used for covering household properties. Therefore, an all-encompassing approach including health education and targeting other malaria prevention methods is recommended.

Besides LLINs, IRS, as is a key national intervention in malaria prevention, was reported performing relatively well in the Northern Region where it has been implemented. However, the use of IRS has been found to have challenges such as community misinformation on insecticides, unpleasant smell, the mess left by the sprayers, and inconvenience of removing household items from houses before spraying.

Malaria treatment guidelines emphasize the high utilization of public/private health facilities and VHTs in rural communities for the treatment of malaria among children under 5 years of age. The challenges of accessing these services established during this assessment included long distance to facilities, inadequate health workers, insufficient number of VHTs, and stock-out of drugs among others.

5.8 Recommendations:

1. Consider the improved investment in community systems to address malaria prevention and treatment literacy among the public such as improvement in bed nets use.
2. Consider the development of malaria prevention and control advocates at all levels.
3. Consider the needs of KPs in malaria programming.
4. Support more investment in recruiting more health workers at facilities with inadequate staff and an increase in the number of community-based health workers (VHTs).

CHAPTER 6: REPRODUCTIVE MATERNAL, NEW-BORN, CHILD AND ADOLESCENT HEALTH (RMNCAH)

6.1 Adolescent Health and Nutrition

6.1.1 Adolescent sexual and reproductive health education and counselling services

Adolescents are one of the age cohorts that the HSDP has put strategic interventions to promote a healthy population and human capital by promoting good nutrition, SRH education in schools and communities. The strategies include the Adolescent Health Strategy (2012) and the Reproductive Maternal, Newborn, and Child Health Sharpened Plan for Uganda (RMNCAH - 2013) among others. Adolescent fertility is thus an issue of policy concern in Uganda. The assessment focused on Adolescent SRH education and counselling services, provision of contraceptives to girls below 18 years, and use of specified SRH services by young people.

Table 61: Adolescent sexual and reproductive health education and counselling services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Adolescent sexual and reproductive health education and counseling services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					

	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The respondents and health workers revealed that services offered by the facilities were average and very good due to availability of youth-friendly services, having youth designated days for counseling, and the existence of youth peer groups that offer an opportunity to youth to be handled privately. In addition, most health workers have been trained on how to offer youth-friendly services. However, some respondents noted that the services were poor because of limited linkage of health facilities with school institutions where the majority of young people stay. Another reason for poor performance was lack of outreach services. Other barriers to the provision of health services to young people reported by healthcare workers entailed limited trained staff and limited dedicated space for young people.

> ***"****Adolescents are well handled under their youth corner only that those below 18yrs are not given FP unless they are married" Woman FGD Participant, Namalu HC III, Nakapiripirit District.*

> *"There are no friendly services for the Youth. The Youth do not like coming when there are crowds, no separate rooms to attend to the Youth issues" Health Worker FGD Participant, Orwamuge HC III, Abim District.*

> *"Most Adolescents who come here and test positive for HIV, they don't come back" Woman FGD Participant, Butama HC III, Bundibugyo District.*

6.1.2: Individual nutrition counseling services at HIV care and treatment sites

Assessment inquired about the individual nutrition services that are available at the HIV care and treatment sites. Table 61 shows the results of this assessment.

Table 62: Availability of Individual nutrition counseling services at HIV care and treatment sites

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of individual nutrition counseling services at HIV care and treatment sites	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					

	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

From the focus group discussions held with the respondents and health workers, it was revealed that services offered by the facilities were average and/or very good given the integration of health education in all services offered at family planning and HIV clinics.

> *"The health workers sensitise us on health services and nutrition though they are most times overloaded with too much to do at the health facility," said one of the participants in the FGD, Bumanya HC IV, Kaliro District.*

> *"This is continuously given in maternity, ART, OPD, immunizations, family planning clinic but there is no nutritionist specialist at facility" Health Worker FGD Participant, Nabisoigi HC III, Namutumba District.*

> *"No money to buy eggs, milk, fish and other vegetables yet eMTCT mothers are told to breastfeed for only 6 months"* Female FGD Participant, *Mayuge HC III, Bugiri District.*

> *"Women are usually sent to Bugiri hospital to pick foods to boost their nutritional levels. However, it is very far and lack transport"* FGD Participant, *Mayuge HC III, Bugiri District.*

6.2 Family Planning Services

6.2.1 Quality of family planning counselling and information

The assessment sought to have information on the availability of FP services and information at the facility and community levels.

Table 63: Availability of family planning counseling and information

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of family planning counseling and	Tororo					
	Mbale					
	Bukwo					

information	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results indicate that most of the participants were satisfied with the availability of family planning services at health facilities. This as a result of training of FP service providers in public health facilities in the provision of long-acting FP methods, service delivery through a variety of models including routine service provision, outreaches, social franchising (through the private sector). It is also attributed to community-based distribution of commodities, task sharing such as community-based distribution (CBD) of injectable contraception by VHTs, tubal ligation by trained clinical officers, and provision of long-acting FP methods by midwives. Participants also mentioned that the provision of counseling services before and after administering of FP/C methods in most health facilities is an enabler to contraceptive use. Couple counseling services in some facilities were also cited by HCPs as being particularly helpful in facilitating male involvement in FP/C services uptake and support. In addition, the participants mentioned innovations such as the voucher scheme, postpartum IUD, and postpartum FP to increase access, integration of FP into other services, and embedding of FP into reproductive health (RH) services and broader community health programs including immunization and HIV/AIDS-related interventions. However, it was reported that sometimes, there were inadequate stocks and limited facility staff, which affect the delivery of FP interventions. Limited partner involvement in utilizing FP services negatively affects the delivery of the services.

> *We are promoting couples counseling in most of the health centers in our district. Not only are we targeting women alone, but also men. We encourage women to come together as couples so that when they want to access family planning, they understand what type of services we offer at the facility level. (Healthcare Provider KI, Nakaseke District)*

> *"Health workers sensitize and teach us on the importance of accessing family planning services at the ART clinic and OPD, Group Counselling is usually provided even at the ANC" FGD Participant, Nyahuka HC IV, Bundibugyo District.*

> *"Men are taught about correct use of male condoms to fight against HIV, STIs and unwanted pregnancies. Also taught about vasectomy" Male FGD Participant, Namwendwa HC IV, Kamuli District.*

> *"Family planning services of all categories are available, clients are counselled before enrolling on any family planning method of their choice", Participant, Nyakwae HC III, Abim District.*

6.2.2 Postpartum/post-abortion family planning counselling and services for women

In addition to International and Regional obligations, Uganda's reproductive health guidelines list provision for Post Abortion Care (PAC) as a component of maternal and newborn health services that should be provided to women who have had an abortion. Therefore, the assessment inquired about the availability of postpartum care family planning counseling services and post-abortion care services offered to the population.

Table 64: Availability of Postpartum/post-abortion FP counseling services for women

Variable	District	Health Facility Level				
		IV	III	III	III	III

Postpartum/post-abortion family planning counseling and services for women	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					

	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

There was generally agreement that postpartum care FP counseling and services and post-abortion care and services were available in facilities assessed. This was attributed to the availability of postpartum care, FP counseling services, and post-abortion care services and training of health workers on the provision of post-abortion service, and availability of supplies that are crucial to the provision of these services. However, participants noted that stigma around abortion affects timely seeking of the services by women. In addition, misconceptions, lack of clarity about the legality of abortion, and the staying of the 2015 Ministry of Health Standards and Guidelines on Reducing Morbidity and Mortality from Unsafe Abortion in Uganda were cited as challenges. Lastly, because of limited legal services for doctors who might conflict with abortion laws, health workers may refuse to offer post-abortion care for fear of being reported to the police.

> *"Women are well attended to. Even younger girls are seen making use of the services" FGD Participant, Namwendwa HC IV, Kamuli District.*

> *"Health workers help women who have aborted and even those who have had miscarriages to stop them from over bleeding and usually they counsel them not to get pregnant when not prepared" Orwamuge HC III, Abim District.*

> *"We are not aware of the availability of the post-abortion services" FGD Participant, Namalu HC III, Nakapiripirit.*

6.2.3 Contraceptive use

The assessment considered the availability of primary health care facilities providing at least three modern FP methods, unmet FP needs, and availability of modern FP commodities at the facility and population utilization.

Table 65: Availability of Contraceptive use services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Contraceptive use services.	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					

	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The assessment revealed that over half of the respondents were satisfied with the services being offered at the health facilities largely because of the availability of supplies such as pills and condoms. They mentioned that condoms and pills were considered more easily accessible and difficult to run out of stock from pharmacies or hospitals. In addition, the respondents reported the fear of contracting HIV and other STIs; therefore, that was the major reason for the use of contraception.

Although the contraceptives are available, there are still barriers to their use. Societal norms that do not support the use of contraceptives at an early age and parent's disapproval still exist. Unmarried women who use contraceptives are stigmatized and perceived to be unfaithful in marriage. In addition, men's decision to use a contraceptive method depended mainly on their religious beliefs, cultural norms and the gender power relations, which put them at an advantage over the women.

> *In every clinic, there is this integration of services. For example, if the client comes for antenatal, we include services like family planning. If she needs to go for ART, the same day she will even go for ART to collect her ARVs. We don't have to let the clients make trips to our clinics. When they come, it's like a supermarket. They move from point A to B to point C, from point C to D, just like that. (Healthcare provider FGD,* Nakasongola HCIV, Nakasongola District)

> *"Family Planning service is provided here and the most available options are the short-term methods" FGD Participant, Butama HC III, Bundibugyo District.*

> *"Contraceptives are available to all the clients that need it…the counselling and information giving is provided to clients" FGD Participant, Kiyunga HC IV, Luuka.*

> *"Levels of contraceptives uptake are very low, there is a traditional belief that "the more children one bears, the more blessings and the more respect within the communit", Male FGD Participant, Nakapelimoru HC III, Kotido District.*

6.2.4 Management of Sexually Transmitted Infections (STIs)

The assessment considered the availability of primary health care facilities for management of sexually transmitted infections.

Table 66: Availability of Management of Sexually Transmitted Infections (STIs) services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Contraceptive use services.	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					

	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Filed Data

The assessment revealed that over half of the respondents were satisfied with the services being offered at the health facilities because of the availability of supplies at the health facilities. They mentioned that the integration of STI management in clinics such as ANC and HIV have been useful in addressing STIs. Besides, participants attributed the good performance to awareness and public education via mass media.

> *"The management of STIs is available only the stock out of some drugs" FGD Participant, Bugaya HC III, Buyende District.*

> *"Diagnosis is done… the clients are not aware of the service but the challenges are in common stock-outs in drugs for management of STIs" FGD Participant, Kiyunga HC IV, Luuka District.*

"Most of the drugs are always out of stock, testing kits not enough but the communities are always willing to have the tests and treatment" FGD Participant, Nakapelimoru HC III, Kotodo District.

6.3 Maternal Health

6.3.1 Pregnant women attending ANC sessions

The assessment sought information on completion rates for pregnant women attending four ANC sessions, dropout rates for ANC visits and reasons for drop out, motivational talks provided by health workers, and involvement of husbands/men/intimate partners.

Table 67: Pregnant women attending ANC sessions

Variable	District	Health Facility Level				
		IV	III	III	III	III
Pregnant women attending ANC sessions	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					

	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The participants revealed that they were happy with the ANC services because of the technical support and monitoring implementation of Health Promotion in most of the districts. In addition, there was monitoring of the effectiveness of SBCC/Health Promotion interventions on service delivery at health facilities in districts. They also mentioned social mobilization in communities through VHTs and film vans as another enabling strategy. The integration of ANC services in HIV clinics has helped to improve ANC attendance.

> *We have VHTs who are based in the community; they explain and provide information on the need to go and see health workers for antenatal care when one is pregnant.* ([Female FGD, Bukomero HCIV, Kiboga District)

Nonetheless, the assessment found that generally, men do not go with women to attend ANC sessions. This was attributed to among others gender stereotypes about the role of men in reproduction. Because of polygamy - having multiple partners, men fear being seen with other women outside their known marriages. Men also fear the possibility of being asked to take HIV tests along with partners during ANC visits. Men claimed that they were busy to accompany women. The non-compliance was attributed to men's poor health-seeking behavior, which influences how they perceive their role in ANC.

> *Most men do not go with pregnant mothers to health facilities because some are married yet they have impregnated women outside marriage. This hinders them from coming with pregnant women to the facilities.* (Female FGD, Rwebisengo HCIII, Ntoroko District)

> *"Women and girls have embraced ANC because of continuously health education, mobilising and sensitisation about the value of ANC" FGD Participant, Kidera HC IV, Buyende District.*

"Completion rate for pregnant women attending ANC is at 70% due to long distances and lack of transport means" Female FGD Participant, Balawoli HC III, Kamuli District.

"Motivated by the trained midwife and free LLINs on first visit" *Health Worker FGD Participant,* Gadumire HC III, Kaliro, District".

6.3.2 Institutional deliveries

Another inquiry sought information on levels of institutional deliveries, access to Emergency Obstetric and New-born Care (EmONC) services, availability of skilled attendants (nurses, midwives, and doctors) on a regular basis, stock-outs of life-saving commodities, and emergency referral system and an emergency transport plan in the community. The team believed that the absence of such services reduces further the confidence of the mothers using the services.

Table 68: Institutional delivery of services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Institutional delivery services	Tororo					
	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					

	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Most of the participants were satisfied with the service. They noted that this was attributed to on job mentoring and coaching conducted in health facilities, which improved the capacity of health workers on provision of Emergency Obstetric and Newborn Care (EmONC) service. The facilities have developed quality improvement plans. There is also social mobilization and health promotion in the community through media and VHTs, and availability of life-saving commodities, which improves the confidence of the mothers in using the services.

However, the participants revealed that there were still some barriers to health facility-based deliveries such as poverty, socio-cultural factors, long distances to health facilities, and lack of transport to health facilities. Other obstacles included limited supplies, drugs and basic infrastructure at health facilities, poor quality of care at health facilities and the perceived friendliness, accessibility and readily availability of Traditional Birth Attendants (TBAs) within communities. Factors related to economic and physical inaccessibility and lack of infrastructure, drugs, and supplies at health facilities were highly ranked barriers to utilization of institutional delivery. In addition, attitudes of health facility staff and previous experiences were mentioned.

> *It depends, if the hospital is close, then you go to the hospital [to deliver] and if the TBA's places are close, then it is the TBA. Getting a means [of transport] at night to take you to the hospital may be a bit difficult; this will make you go to a TBA. (Female Participant,* Paya HCIII, Tororo District)

> *Sometimes the labor pain may begin when you are with your spouse and you tell him to accompany you to the hospital since you can't walk on foot. He will respond that he is busy and he doesn't have money to take you to the hospital. This will force you to deliver at home because even if you go to the hospital,*

he says that he warned you not to go there because he has no money. (Female Participant, Aboke HCIV, Kole District)

"As a result of community sensitisation on the benefits of ANC towards having a safe child and mother, many women deliver from health facilities" FGD Participant, Kidera HC IV, Buyende District.

"Many women now know the importance of attending ANC sessions towards the health and wellbeing of the women and children and so opt for institutional deliveries" FGD Participant, Ikumbya HC III, Luuka District.

"Many mothers still deliver from the community due to lack of transport and long distances since the facility serves the entire sub-county". FGD Participant, Bugaya HC III, Buyende District.

6.3.3 Availability of cervical cancer routine screening and treatment services

The study assessed the availability of routine cervical cancer screening services, promotional education about cervical cancer screening as part of the health services the facilities offer.

Table 69: Availability of cervical cancer routine screening and treatment services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of cervical cancer routine screening and treatment services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					

	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

More than half of the participants were unsatisfied with the services being offered by the health facilities. They argued that a feeling of embarrassment perceived pain during the examination, fatalism associated with a diagnosis, unsupportive husbands/partners and limited awareness of cervical cancer and available services that rendered the services poor. The barriers notwithstanding, most women participants were interested in receiving cervical cancer screening regularly and cited reasons such as the need to know their status, prevention of cervical cancer, and obtaining treatment if they had the disease. They suggested that community mobilization and education, peer-to-peer engagement, and organizing health systems to track and follow-up women would mitigate barriers and optimize chances of screening programs.

> *We hear that when you come here for screening, the health workers handle you as if you are going to give birth. They roughly insert equipment inside and you feel pain. When women come and hear it's the same method, very few will go there. (Female Participant, Bbale HCIV, Kayunga District)*

…. the part that is affected by that cancer makes us uncomfortable when it comes to showing the health worker. This testing method should be improved. (Female Participant, Bbale HCIV, Kayunga District)

"The participants are not aware of the cervical cancer screening and treatment services in the facility but referrals to Abim hospital are made" FGD Participant, Nyakwa HC III, Abim District.

"The facility is not a credited for the routine cervical cancer screening and treatment services… the community is not sensitized about the services" FGD Participant, Balawoli HC III, Kamuli District.

"Routine cervical screening is only done by partners. The service is not at the health facility" Health Worker FGD Participant, Kidera HC III, Buyende District.

6.3.4 Availability of Breast Cancer routine screening services

The study assessed the availability of routine breast cancer screening services and the availability of promotional education about breast cancer screening as part of the health services the facilities offered.

Table 70: Availability of Breast Cancer routine screening services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of cervical cancer routine screening and treatment services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					

	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Majority of participants were unsatisfied with the services being offered by the health facilities. This was due to limited awareness of breast cancer screening. Furthermore, there were limited staff at health facilities; the health workers in ANC clinics could not examine women because they would not be able to serve all mothers that come for ANC services.

6.3.5 Availability of friendly services (paternal responsibility and men only services)

Table 71: Male friendly services (paternal responsibility and men only services)

Variable	District	Health Facility Level				
		IV	III	III	III	III
Male friendly services (paternal responsibility and men only services).	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					

	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Almost half of the participants reported that the availability of male-friendly services was poor since most services target women and children and men feel left out. Secondly, the majority of men do not escort their spouses to the health facilities; therefore, they do not have opportunities of being engaged in health education. Participants suggested that male-friendly services should be put in place such as cancer screening so that men are attracted to the health facilities.

> *"Male friendly services are not available, emphasis is only put on women services", FGD Participant, Lukolo HC III, Jinja District.*

"Men don't support their women to go for family planning. There are no services targeting men alone except VMMC", Male FGD Participant, Orwamuge HC III, Abim district.

6.4 Child Health

6.4.1 Integrated Management of Childhood Illness services and commodities

The assessment sought information on the availability of commodities such as ACTs, antibiotics, zinc, Vitamin A, and ORT for children under five at the facility; quality of client-provider interaction including attitudes of health workers; and children nutrition education offered to mothers.

Table 72: Availability of Integrated Management of Childhood Illnesses services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Integrated Management of Childhood Illnesses services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					

	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

From the results above, the participants were satisfied with the services. The reasons given for the high scores included social mobilization through media and community health workers (VHTs), trained health workers, and availability of commodities such as ACTs, antibiotics, zinc, Vitamin A, and ORT both at the health facilities and with VHTs.

"Management measures for childhood illnesses are available and integrated into the mainstream health care package" FDG Participant, Bwizibwera HC IV, Mbarara District.

6.4.2 Children under one year immunized with third dose pentavalent vaccine

The assessment found out information on success rates and factors that motivate mothers to bring children for immunization and any health promotion interventions conducted at the facility and community levels.

Table 73: Children under one year immunized with 3rd dose Pentavalent vaccine

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability of Children under one year immunized with 3rd dose Pentavalent	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					

vaccine	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Table 72 shows that more than two-thirds of the participants were satisfied with the services. The participants justified their high scores based on the following reasons: health promotions conducted in the community through media and VHTs, availability of commodities at health facilities, outreach services conducted in the communities.

6.4.3 One-year-old children immunized against measles

The assessment sought to establish the completion rates as well as factors that motivate mothers to bring children for immunization. It had been reported that although access to immunization services for one-year children was doing well; still some mothers were not completing the whole schedule.

Table 74: One-year-old children immunized against measles services

Variable	District	Health Facility Level				
		IV	III	III	III	III
Availability one-year-old children immunized against measles services	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					

	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Most of the participants were happy with the services offered at the health facilities, attributing to advocacy and social mobilization and advocacy on routine immunization; dialogue meetings with health workers, engagement of the media, availability of commodities, and government deliberate policy to implement the immunization interventions through both static and outreach services. Besides, technical support and monitoring implementation of Health promotion interventions in most of the districts was noted as one of the critical enablers for the success of the immunization program.

> *"The immunization against measles has great support from the government and therefore a lot of radio talk education is conducted to mobilize the mothers" FGD Participant, Nambale HC III, Iganga District.*

6.4.4 Conclusions and Recommendations

Although most services assessed showed good ranking on several indicators and participants were satisfied with the services, several barriers require attention, including inadequate staffing, inefficient supervision, and poor health infrastructure.

1. Increased investment in health promotion and disease prevention interventions to reduce the disease burden and increase funding to address the gaps in health service delivery.

2. Cervical cancer screening was noted as poor highlighting an urgent need to prioritize sensitization and provision of communities with adequate information about cervical cancer.

3. Build the capacity of available female health workers some of whom may be of lower cadres such as nurses and midwives through task shifting to carry out cervical cancer screening of women with support from other staff.

4. Health facilities should have adequate capacity including skilled and professional workforce and required supplies and logistics to provide quality screening services to women.

6.5 Gender services availability

6.5.1 Availability of Integrated Strategies to prevent GBV and HIV

The assessment inquired about strategies in the community and health facilities to handle issues of GBV, whether cases of GBV are reported, a mechanism for referral and mitigation and follow up, and availability of gender-sensitive tools.

Table 75: Availability of Integrated Strategies to prevent GBV and HIV

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of Integrated Strategies to prevent GBV and HIV	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					

	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Participants ranked the services as good, while others ranked them as average. The good ranking was attributed to the training of health workers on the management of GBV, provision of supplies and equipment for managing GBV cases, support supervision of health workers, documentation of GBV cases, and mentorship for health workers to provide GBV survivor friendly services. It was noted that in some communities, there are community-based structures such as VHT, paralegals, and para-social workers to provide gender and HIV related services. However, while HIV, GBV, and SRH services exist in most health facilities, they are not integrated; therefore, clients must seek help from different units within the health centers and sometimes from different health centers depending on the specific conditions to be addressed. Participants suggested an integrated one-stop-service provision center that ensures comprehensive, effective and efficient delivery of health care services to clients.

> *"Cases of GBV are reported but follow up is a challenge due to financial constraint" FGD Participant, Balawoli HC III, Kamuli District*

> *"Health workers, LCs and VHTs all work hand in hand to sensitize people not to victimize PLHIV" FGD Participant, Nyakwae HC III, Abim District*

6.5.2 Availability of interventions to address harmful cultural practices

The Assessment inquired about harmful cultural practices such as child, early and forced marriage, payment of dowry and bride price, under-valuing of women and girls and female genital mutilation practices that increase women and young people's vulnerability to HIV infection and other health-related complications. It also inquired about mitigation mechanisms, referral and follow up.

Table 76: Availability of interventions to address harmful cultural practices

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Availability of interventions to address Harmful	Tororo					
	Mbale					
	Bukwo					

cultural practices	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results indicate that the participants were not satisfied with the services that address harmful cultural practices. They noted that practices such as forced marriages, rape, and defilement, demanding high bride wealth by parents were still widely practiced. Cases involving such practices were being settled out of court or not reported to the police. Such practices heighten women and girls' vulnerability to GBV and HIV&AIDS. It was further reported that there were limited or non-operational community referral structures that would help those affected.

> *Women are sometimes the sole drivers of violence against themselves because they are unfaithful in their marriage. (Male FGD Participants, Rwebisengo HCIII, Ntoroko District)*

> *Men don't know where to go when their rights are violated. They feel shy to report cases when their rights are violated considering their social status. (Male FGD,* Buhanuka HC III, Hoima District)

> *"LCs, community courts and the police address these practices, rape, assault, defilement, SGBV, and other family conflicts are well attended too" FGD Participant, Orwamuge HC III, Abim district*

> *"Some cultures here believe that when a woman has not given birth, she is denied the right to own her husband's property" FGD Participant, Lotome HC III, Napak District.*

6.6 Human Rights Services

6.6.1 Existence of Criminalization of Key Populations and People living with HIV

The study inquired about the existence of laws that criminalize such populations as sex workers, people who use drugs, gay men and other men who have sex with men, transgender people, and people living with HIV. It also sought information on whether people are aware of the criminalization laws and how the laws affect these people.

Table 77: Existence of Criminalization of specific populations

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Existence of Criminalization of particular populations	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					

	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Respondents believed that there were laws that criminalize the key populations. For example, the Penal Code. Important to note also is the fact that some respondents were not aware of the laws that criminalize Key Populations and People living with HIV.

> *"Key populations are criminalised. Once identified, one will be despised, assaulted, punished and made to pay fines" Health Worker FGD participant, Lotome HC III, Napak District.*

6.6.2 Stigma and discrimination in education, employment, and health care institutions

The assessment solicited information on levels of violence, stigma and discrimination and denial of health care services. It also inquired about those who have been denied opportunities to education, employment, and health care, e.g. children and women.

Table 78: Stigma and discrimination in education, employment, and health care units

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Stigma and discrimination in education, employment, healthcare	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					

	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

More participants reported that there were high levels of stigma and discrimination coupled with denial of health care services especially for key populations. They noted that fear of stigma and discrimination is still a big barrier to accessing health care and treatment services. Fear of being blamed and possible GBV also continue to be a barrier to access to services. In some situations, PLHIV are not involved in community support groups organized by other community members. Community social mobilization and working with PLHIV networks and other community-based health workers would address such stigma and mobilize for acceptable attitudes from community members towards PLHIV. Denial of employment such as working as a house help in homes, and denying children living with HIV access to education were some of the issues mentioned by participants.

> *It's very hard to believe that you can leave your young children to be looked after by a girl whom you know has AIDS* (Female Participant, Puranga HCIII, Pader District)

> *"Levels of stigma and discrimination are very high around Lotome community, if people discover that you are HIV positive, they migrate to another village and abandon you there" FGD Participant, Lotome HC III, Napak District.*

> *"As a health facility, we do not discriminate people. We offer services to everybody who visits the health centre" Health Worker FGD Participant, Nyahuka HC IV, Bundibugyo District.*

6.6.3 Existence of Community justice sectors

The assessment further sought information on the existence of community justice sectors like LCs, police, and family courts.

Table 79: Existence of community justice sectors

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Existence of community and	Tororo					
	Mbale					

justice sectors against people living with HIV	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					

	Kampala					

Source: Field Data

Respondents reported the existence of structures such as family courts/meetings, or LCs that meet to discuss issues regarding people living with HIV. These have been involved in cases like property sharing and custody of children after the death of a partner. They noted that such meetings in most cases rule against the widows or children.

Some respondents reported that there was less or no discrimination against persons living with HIV; such courts or meetings do not condone such behavior. They noted that several community structures exist in most communities across the country to support women and girls as well as men and boys living with HIV. These include family support groups, post-test clubs, Positive Men's clubs, burial groups, and other agency groups. These structures are composed of community members who strive to provide necessary information to other community members and offer counsel. Some of these structures have been trained and mobilize the community members including families, LCs, and police on the plight of people living with HIV.

The participants also noted that many community-level groups that used to be vibrant in supporting individuals and families affected by HIV have weakened or collapsed due to the harsh economic conditions, death of key members, or lack of support. There is a need to scale up the establishment of community structures in communities where they do not exist and to institutionally strengthen the existing ones. They further suggested that all the Local Council I and II structures, which are critical in identifying and supporting victims, and handling or referring cases of discrimination against PLHIV and GBV, be mobilized and trained to intervene in PLHIV cases and help affected families seek justice. Furthermore, legal literacy campaigns should be implemented in communities to ensure that those who have been discriminated against due to their health or social status are educated on their rights.

> *"The police and LCs are doing a great job however there is too much bribery and corruption which money is not affordable by the vulnerable persons" FGD Participant, Ikumbya HC III, Luuka District.*

> *"The police are corrupt and have a negative attitude towards the marginalized. When you don't have money, they don't want to work on you" FGD Participant, Butama HC III, Bundibugyo District.*

6.6.4 Violations of women's property and inheritance rights

The assessment inquired whether violation of women's rights is a common occurrence and whether women are being denied access to the property.

Table 80: Existence of violations of women's property and inheritance rights

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Existence of violations of women's property and inheritance rights	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					

	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					
	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results indicated that there are violations of women's rights in communities. Such violations involve denial of accessing property, arbitrary eviction from the housing, lack of access to justice especially where children

have lost their partners. It was reported that access to justice for all of these abuses is hindered not only by the lack of a supportive legal framework and standard mechanisms for redress, but also by context-based factors. These factors include limited knowledge of rights among people living with HIV and those at risk, judicial corruption, inability to identify perpetrators, limited access to and affordability of legal aid services. Others include stigmatization, discrimination and powerlessness that stem from being a member of socially marginalized groups.

> *"Women's property is grabbed by in-laws and men even sell off women's property" FGD Participant, Namalu HC III, Nakapiripirit District.*

> *"Violation of women property is still occurring in this community because the culture here is that women are not supposed to own and inherit land but men" Female FGD Participant, Kiyunga HC IV, Luuka District.*

6.6.5 Limited access to HIV prevention and treatment for incarcerated populations

The assessment inquired into whether incarcerated populations have access to HIV services and whether communities know that people in prisons have a right to health services.

Table 81: Access to HIV prevention and treatment for incarcerated populations

Indicator	District	Health Facility Level				
		IV	III	III	III	III
Lack of access to HIV prevention and treatment for incarcerated populations	Tororo					
	Mbale					
	Bukwo					
	Kole					
	Otuke					
	Alebtong					
	Dokolo					
	Apac					
	Amolatar					
	Amuru					
	Pader					
	Lamwo					
	Rubirizi					
	Kisoro					
	Ntoroko					
	Hoima					
	Bulisa					
	Masindi					
	Kagadi					
	Kyankwanzi					
	Nakaseke					
	Nakasongola					

	Kiboga					
	Luwero					
	Kalangala					
	Buikwe					
	Buvuma					
	Kayunga					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Half of the respondents mentioned that there was a lack of access to HIV prevention and treatment for incarcerated populations. They reported that people living with HIV are often the most vulnerable and stigmatized segment of the prison population. Fear of HIV&AIDS often places HIV-positive prisoners at increased risk of social isolation, violence, and human rights abuses from both prisoners and prison staff. This fear is often driven by misinformation about HIV transmission and the false belief that HIV infection may be spread by casual contact. However, this discussion was not concluded since we did not interview prisoners or prison staff to corroborate the findings. It was recommended that since everyone in society is a potential prisoner, community sensitization on the rights of prisoners be conducted. This would also enable relatives to ensure that the person who is in prison is given access to health services.

> *"They are allowed to get treatment on specific days. However, there is no confidentiality as the incarcerated centres converge so many people where issues of privacy can't be observed" Health Worker, FGD Participant, Tokora HC III,* Nakapiripirit District.

> *"All incarcerated people access their treatment and follow up is done to ensure that they continue receiving their treatment, unless when they are taken very far" FGD Participant, Bumanya HC IV, Kaliro District.*

6.6.6 Legal Environment concerning KPs

The assessment inquired about the legal environment regarding key populations. The areas considered included; friendliness by health workers and general community towards key populations, prevalence of discrimination and existence of criminalization of KPs, knowledge of laws, and access to legal support.

6.6.7 UNFRIENDLY HEALTH WORKERS AND COMMUNITY IN GENERAL POPULATION

Table 82: Unfriendly health workers and community in general Population

Variable	District	Facility Level		
		HC III		HC IV
Unfriendly health workers and community in general	Abim			
	Kotido			
	Kaabong			
	Napak			
	Amudat			
	Nakapiripirit			
	Kamuli			
	Buyende			
	Luuka			
	Kaliro			
	Jinja			
	Iganga			
	Bugiri			
	Namutumba			
	Yumbe			
	Kitgum			
	Mbarara			
	Bundibugyo			
	Kampala			

Source: Field Data

The assessment shows that most respondents believed that service providers and community attitudes are unfriendly to KPs. Participants attributed this to religious, socio-cultural, and gender-based norms, values and stereotypes that contribute to varying levels of disapproval, exclusion, and even persecution of persons and groups associated with these identities, orientations, and behaviors. Also, in some health care settings, the environment translates into judgmental attitudes, hostility, labelling, and discrimination in the delivery of services. As a result, this affects adherence to care and retention in services. However, they noted that orientation of health workers on the needs of KPs and social mobilization of the public mostly NGOs could lead to better results.

"The cases of unfriendly workers and general community are very minimal due to knowledge of rights of the patients" Nankoma HC IV, Bugiri District

6.6.8 PREVALENCE OF DISCRIMINATION AND MARGINALIZATION OF KPS

Table 83: Prevalence of Discrimination and marginalization of KPs

Variable	District	Facility Level	
		HC III	HC IV
Prevalence of Discrimination and marginalization of KPs	Abim		
	Kotido		
	Kaabong		
	Napak		
	Amudat		
	Nakapiripirit		
	Kamuli		
	Buyende		
	Luuka		
	Kaliro		
	Jinja		
	Iganga		
	Bugiri		
	Namutumba		
	Yumbe		
	Kitgum		
	Mbarara		
	Bundibugyo		
	Kampala		

Source: Field Data

Almost half of the respondents reported that there was discrimination against KPs attributed this to prejudice, exiting laws and societal norms and values. However, equally same number of respondents mentioned that discrimination doesn't exist and noted that available health services were accessible to everyone that seeks for the services.

> *"This is very high; the reason is that the law in Uganda does not support their actions like especially the gays and the people who inject the drugs. The sex workers are also not accepted for their immoral actions according to community" FGD Participant, Bugembe HC IV, Jinja District.*

> *"Here KPs are highly criminalized and even associating with them is also criminal. Once known, you will be forced to flee to another area and the family will disown you" FGD Participant, Kathile HC III, Kaabong District.*

> *"Health workers have not attempted to discriminate any of us but discrimination and marginalization do exist in the community for KPs" FGD Participant, Lukolo HC III, Jinja, District*

Table 84: Existence of Criminalization of KPs

Indicator	District	Health Facility Level

		Referral	IV	III	III	III
Existence of Criminalization of KPs	Lira					
	Wakiso					
	Kasese					
	Busia					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results above show that majority of respondents believed that some laws and practices criminalize KPs. The participants sighted laws such as Penal Code which Police use to arrest KPs especially Sex Workers.

We face high discrimination from police as drug users. (Drug User KP, Ober HC III, Lira District)

Table 85 Awareness of Rights and the Law among KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Awareness of rights and the law	Lira					
	Wakiso					
	Kasese					
	Busia					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					

	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results above show that the participants had a fair view of awareness of their rights and law. Some participants reported that they knew their rights, and mentioned rights such as not to be tortured, being produced in court within 24 hours, the right to be given food, and the right to be visited by friends and family members. They mentioned that this is an era of rights and that several organizations are trying to promote the rights of vulnerable groups like them. They attributed their awareness to some of the media campaigns, outreaches, and human rights training undertaken by human rights CSOs and peer education system. However, they complained about police that demand money to be released, which affects their ability to exercise their rights and push back when violated and/or extorted by law enforcement.

> *"Since there are no KPs, the participants are not sure whether KPs are aware of their rights", FGD Participant, Lotome HC III, Napak District.*

> *"No known laws and rights about KPs", FGD Participant, Kiyunga HC IV, Luuka District.*

Table 86: Frequency of KPs encounters with Police

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Frequency of KPs encounters with Police	Lira					
	Wakiso					
	Kasese					
	Busia					
	Abim					
	Kotido					
	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					

	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

Results from the assessment indicated that the majority of the respondents reported that police often arrest KPs. sometimes; they are arrested because they are perceived to be idle or when they are found using drugs.

> *Sometimes, the police come and pick us from our homes just because we sleep more than one in the house. They cut off our hair and nails among other things. (KP Respondent, Busia HCIV, Busia District)*
>
> *KPs are arrested by police, but after a few days, they are released. (General Population Male Participant, Abala, HC III, Lira District)*
>
> *When police arrest them, they treat them badly. (General Population Participant, Kasagati HC IV, Wakiso District)*
>
> *During festive seasons, the encounters with police often raise, they are high to almost daily every evening. (KP Participant, Busia District)*
>
> *"The police rarely arrest these groups because they operate in hiding unlike in the bigger towns, it is the drug abusers arrested sometimes when found idle and disorderly" FGD Participant, Nyahuka HC IV, Bundibugyo District.*
>
> *"The police have not arrested us because we are clever and we know how to do our work" FGD Participant, Kotido HC IV, Kotido District.*
>
> *"The KPs who use drugs that are against the law are the only ones the police can run after because of drug abuse but the sex workers have no issues with police" Nambale HC III, Iganga District.*

Table 87: Access to legal and other support services by KPs

Indicator	District	Health Facility Level				
		Referral	IV	III	III	III
Access to legal and other support services	Lira					
	Wakiso					
	Kasese					
	Busia					
	Abim					
	Kotido					

	Kaabong					
	Napak					
	Amudat					
	Nakapiripirit					
	Kamuli					
	Buyende					
	Luuka					
	Kaliro					
	Jinja					
	Iganga					
	Bugiri					
	Namutumba					
	Yumbe					
	Kitgum					
	Mbarara					
	Bundibugyo					
	Kampala					

Source: Field Data

The results in Table 84 show that the majority of participants were not satisfied with accessibility to legal and other social support for KPs. Over two-thirds of the respondents attributed this to a lack of paralegal teams trained to support KPs. In addition; there are no psychosocial support mechanisms in place to provide support in key aspects of KPs' mental health. However, where services existed, it was reported that they were not much publicized because of the general populations' perception of KPs. Therefore, the ongoing capacity building of paralegal teams across various KP sub-groups to provide legal support and referrals when needed should be strengthened. Besides, there should be support for the establishment of peer support mechanisms among KP communities and groups.

> *[We are] Not aware of any paralegal system in place. (General Population Participant, St. Paul HC IV, Kasese District)*

> *We don't have legal advocates in Lira. I have ever heard of only one CBO supported. (Health Worker Participant, Ober HC III, Lira District)*

> *"There is knowledge gap on the available legal and support services for KPs" FGD Participant, Lukolo HC III, Jinja District.*

> *"These groups of people rarely access legal and social support because they are in existence illegally and also are fearful of the consequences of the law, they cannot get justice because they operate on the wrong side of the law" FGD Participant, Biharwe HC III, Mbarara District.*

6.6.9 Conclusions and Recommendations for general Population

a) Most people opt to utilize LC Courts to resolve their disputes. Therefore, the courts play a significant role in promoting access to justice and should be empowered to deal with violations relating to HIV/AIDS, GBV, and rights of KPs.

b) Limited awareness of rights and entitlements among people living with, affected by, and at risk of HIV is a major barrier to effective enforcement of these laws. Support should be given to disseminating these rights and entitlements.

c) Within the realm of direct service delivery, government and other partners should integrate a rights component for patients and others affected within existing health service delivery programs.

d) Legislative and policy advocacy is required to address the deficiencies in various HIV policies and laws, secure a formal conclusion of rights-based policies and laws, and ensure enforcement of rights-based policies and laws.

e) Support institutional and programming capacities of most organizations working at the intersection of HIV, human rights, and law in Uganda.

6.6.10 Conclusions and Recommendations for Key Populations

One common theme that emerges from this community scorecard assessment is that programs targeting KPs should establish and scale-up innovative, community-led services while expanding the integration and options for KP within the health system. Besides, there will not be sustainable improvements in outcomes if interventions do not address the stigma, discrimination, and violence that KPs experience at the hands of family, community members, health care providers, and the state. As more evidence on KP programs emerges, the national stakeholders must prioritize these advances with supportive policies that promote widespread uptake of effective approaches.

Therefore, the assessment recommends as follows:

1. Revise the KP service package to include screening and immunization against hepatitis A and B virus; routine screening for cancers; routine assessments of drug, alcohol and tobacco use; screening for problems related to mental health, post-traumatic stress, stigma and discrimination and experiences with domestic violence and hate crimes
2. Develop and disseminate materials that provide information to KPs on available services and safety at facilities.
3. Provide information aimed at the general population to increase their understanding of KPs issues and reduce isolation, stigma, and discrimination.
4. Provide information to service providers to ensure that all providers are considerably informed of key aspects of KP health.

CHAPTER 7: Systems Strengthening

7.0. Infrastructure, utilities, equipment and staffing levels

The availability of adequate utilities such as water, sanitation, and hygiene encourage patients to visit health care facilities. It also reduces re-infection and co-infections. An assessment of the infrastructure, utilities, and equipment focused on the availability of good and safe water; availability of transport; adequate staff accommodation; adequate toilets, kitchen, shelter, communication facilities; and availability of power and type of power available.

7.1. Availability of clean and safe water

The availability of clean and safe water, proper sanitation, and hygiene is critical in ensuring that patients do not contract water bone diseases and encourages repeat visits. As per the Ministry of Health guidelines, there should be a water source to supply the facility; water should be connected especially to the laboratory, theatre (where it exists), delivery room, laundry area, bathrooms, and other key sections requiring direct water connections across all facilities.

Findings indicate that water shortages regularly occur, while water sources are far from the facilities and water storage tanks are inadequate.

Recommendations

- Install running water at all health facilities and/or provide additional water storage units such as tanks so that water can be harvested and/or stored.

7.2. Availability of transport

Transport means for the health facility is considered a major fundamental means for strengthening linkages through referral support and outreach programs. From the discussions with key informants across all health centre IIIs, it was reported that there was a lack of ambulance vehicles, motorcycles, and facility-specific vehicles. Where an ambulance existed, it was reported that it was expensive for patients to meet the cost of fuelling the ambulance. It was also costly for health facilities to maintain it in good condition due to poor road networks, which often led to its breakdown.

> *[There is] No transport and this affected referral. Last year, we lost a mother because of lack of transport; the ambulance requested from Luwero hospital took long to reach. [It is] Expensive for mothers to foot the fuel bill or hire private transport. (Health Worker, Katikamu HC III, …)*

> *No ambulance or any other means of transport; we use boda boda as our means of referral, that's when your husband has money. (Female participant, Bukalasa HC III, …)*

Recommendations

- The Ministry of Health/Local Government should provide ambulances and motorcycles to health centres to support the referral system and outreaches.

7.3. Adequate number of staff houses

Ministry of Health guidelines for staff accommodation requires that every health worker should be housed at the health facility. The community scorecard assessed the availability of staff houses and the status of the structures at the facilities. This was further validated in the observations and lamentations on the shortage of houses. Even where accommodation facilities existed, they were either not enough or they were in a dilapidated state.

"Health workers may not perform well because of lack of accommodation. Patients may come at night when health workers are not available" (Male participant, Kikamulo HC III …)

"Available accommodation facilities are inadequate, shared and in bad shape. You cannot host your spouse or children because of limited space; such situation may have negative social implication for our marriages" (Health Worker, Semuto HC IV, …)

Staff Houses at Semuto HC IV, Nakaseke District

Accommodation for health workers, especially enrolled midwives and nurses, is lacking. This was evident in Najjembe where the midwife was sleeping in the same room with mothers who had delivered because her house was on the verge of collapse and she feared for her child. 'Our midwife here only eats beans because she cannot eat meat after delivering a mother and the room is smelling blood that she shares with them due to lack of accommodation for her." Male respondent, Najjembe ….

Recommendations

- Construct more staff houses and renovate the existing ones.

7.4 Adequate toilets, kitchen, and shelter

In a bid to support access to services at the facility; toilets, kitchen, and shelter necessitate complementing adherence to services. Observations further revealed the number of toilets was not enough with cases of patients (both females and males) including staff sharing the available facilities. There were no kitchens and shelters. Patient caretakers were preparing their meals from the open spaces and no shelters were available in the majority of the facilities.

7.5. Communication facilities

The availability of systems and practices for ensuring delivery of quality health care was assessed based on the suggestion box, a telephone booth or public payphones, landline facilities, emergency numbers for patients, telephone handsets, radio calls, and notice boards among others, which are critical in obtaining clients' opinions or receiving feedback about the health facility or its services. The poor rating was because most of the communication items for patients' use were almost non-existent. There were no suggestion boxes, facilities for landlines or desk computers. Furthermore, there were no internet and official emails; staff use personal emails and personal mobile phones to communicate with their partners and supervisors.

Recommendation

- Provide communication equipment (suggestion boxes, telephone booths or public payphones, facility landlines, desk computers, and internet).

7.6 Availability of consultation rooms

Consultation rooms support counselling through improving privacy and confidentiality among the services to develop health-seeking behaviour. The scorecard accessed patients' privacy, confidentiality among the health works, and other necessary equipment needed to support patients to seek services and consult on the disease. Results show that the availability of consultation rooms was average in most health facilities. The poor ranking was based on the limited space and rooms to allocate a consultation room and limited privacy during consultations in facilities where they existed. It was recommended that more space be availed to enable smooth consultation processes between patients and service providers.

7.7. Availability of power and type of energy source

Power in health facilities complement and support the delivery of services. The scorecard assessed power extension to the laboratory, maternity wards and delivery rooms, regularity of power supplied, and the different power supplied. This was assessed as very poor or poor because of lack of electricity (hydropower) and solar panels, poor solar batteries, some wards not having power, and frequent power blackouts.

Recommendation

- The government should connect facilities to the national grid (UMEME), generators (with fuel), and solar panels should be installed and have budgets for fuel to run generators.

7.8. Health Facility staffing levels

The results indicate that the staffing levels were generally fair. The results of the assessment of the staffing levels for the 45 health threes indicate that 25 facilities were above 70%, 10 were between 60-70%. Six facilities were between 50-60%, while only 4 facilities were reported to be below 50%. For health center IVs, the results indicate that out of 13 facilities assessed, 11 facilities were above 70% and only 2 were between 65-70% of the staffing level.

However, the results reveal that 5 out of 13 Health IV centers assessed did not have the position of Senior Medical Officer filled while 22 of the 45 Health Centre IIIs did not have Senior Clinical Officers in place. This was reported to have a bearing on the performance of care providers because they are overwhelmed.

7.9. Health Facility equipment

The assessment of the health facility equipment showed that majority of Health Centre IVs lacked liver and kidney function testing equipment and other equipment such as X-ray machines and CT scan. Most HC III facilities did not have infection control equipment like electric dry heat sterilizers; they also lacked examination light (flashlights), refrigerators and ECG.

CHAPTER EIGHT: Community Scorecard Recommendations

HIV Prevention • Ensure that combination prevention interventions are delivered as a package across all communities. • Ensure that service integration is effective and programs address social-structural barriers in their designs. • Ensure that priority prevention interventions are reaching the most in need. • The NSP, which is currently undergoing revision, should incorporate new and emerging population groups like PWIDs and LGBTIs to expand and further strengthen the KPs response. • Conduct social mobilization on HIV self-testing among KPs.	**Care & Treatment** • Provide more space for young people at each health facility. • Train health workers in the provision of youth-friendly services. • Conduct adolescent targeted services, especially during school holidays. • Create a safe environment in schools to address stigma through linkages between health and school system. • Address infrastructure constraints at health centers to ensure admission of TB patients in the same wards with other patients. • Support community structures to support TB interventions. • Conduct training in home-based care services. • Facilitate and motivate community resource persons to enable them to provide home-based services.
Social Support and Protection • Support CBOs to implement community awareness about social protection and anti-stigma interventions. • Scale-up legal support services to enhance the rights of PLHIV, KPs, and other vulnerable categories.	**Malaria** • Invest in community systems to address malaria prevention and treatment literacy among the public including improvement in the use of bed nets. • Support malaria prevention and control advocates at all levels. • Invest in the recruitment of more health workers and increase community-based health workers (VHTs).
Tuberculosis • Strengthen community systems through CSOs/CBOs to improve public knowledge/literacy about TB aimed at reducing stigma and improving adherence to TB treatment. • Develop an advocacy plan aimed at mobilizing public and policymakers towards prioritizing TB interventions at various levels. • The Ministry of Health TB program should continue to invest time and resources in CQI through regular support supervision, capacity building of health workers and prioritizing	**Gender and human rights** • Since most people opt to utilize the LC Courts in resolving their disputes, the courts should be capacitated to deal with violations relating to HIV/AIDS, GBV, and rights of KPs. • Support dissemination of the rights and entitlements people living with, affected by, and at risk of HIV. • Within the realm of direct service delivery, government and other partners should integrate a rights component for patients and others affected within existing programs of health service delivery. • Legislative and policy advocacy is required to

<table>
<tr>
<td>better management of people with TB.
• Consider investment in the decentralization of TB/HIV services to lower-level facilities, use of outreach and differentiated service delivery models by involving community-based structures (VHTs, TB patient groups, CSOs, CHEWS) and out to non-traditional vulnerable populations like fishing communities.
• Set up a motivation plan for TB focal persons and increase the number of staff managing TB.
• Increase investment in the infrastructure to provide adequate accommodation for TB inpatients</td>
<td>address the deficiencies in various HIV policies and laws to secure the formal conclusion of rights-based policies and laws, and ensure enforcement of rights-based policies and laws.
• Support institutional and programming capacities of most organizations working at the intersection of HIV, human rights and law in Uganda.</td>
</tr>
<tr>
<td>Reproductive Maternal, New-born and Child and Adolescent Health (RMNCAH) Services
• Invest in health promotion and disease prevention interventions to reduce the disease burden and increase funding to address the gaps in health service delivery.
• Improve cervical cancer screening, focusing effort on reducing barriers and enhancing facilitators through measures such as raising awareness about the disease, strengthening health systems capacity, and using female health workers to carry out screening.
• Build the capacity of available female health workers to carry out cervical cancer screening of women with support from other staff.
• Health facilities should have adequate capacity, including skilled and professional workforce and required supplies and logistics to provide quality screening services to women.</td>
<td>Key populations
• Revise the KP service package to include screening and immunization against hepatitis A and B viruses; routine screening for cancers; routine assessments of drug, alcohol and tobacco use; screening for problems related to mental health, post-traumatic stress, stigma and discrimination and experiences with domestic violence and hate crimes.
• Develop and disseminate materials that provide information to KPs on available services and safety at facilities.
• Provide information aimed at the general population to increase their understanding of KP issues and reduce isolation, stigma, and discrimination.
• Provide information to service providers to ensure that all providers are informed of key aspects of KP health.</td>
</tr>
<tr>
<td colspan="2">Systems Strengthening
• Revise staffing norms to take into consideration the growing population and range of services provided.
• Install running water and provide additional water storage units such that water can be harvested and/or stored.
• Provide ambulances and motorcycles to support referral system and outreaches.
• Construct more staff houses and renovate the existing ones.
• Provide communication equipment (suggestion boxes, telephone booths, or public payphones, facility landlines, desk computers, and internet).
• Avail more space to enable smooth consultation processes between patients and service providers.
• Connect all facilities to the national electricity grid, or procure generators and solar panels.</td>
</tr>
</table>

APPENDICES

Appendix I: INPUT TRACKING TOOLS-EQUIPMENT- STATUS

Health Center IV-Equipment

Variables	Mulanda	Bufumbo	Aboke	Dokolo	Amolatar	Atiak	Padibe	Rugazi	Busanza	Karugutu	Bulisa
INPATIENT AND OBSERVATION BEDS											
Inpatient beds for adults and children											
Dedicated beds for maternity											
COMMUNICATION											
Existence of a functional cellular telephone or a private cellular phone											
Existence of a functional short-wave radio for radio calls											
Existence of functional computer(s)											
Access to email or internet within the facility											
AMBULENCE/TRANSPORT FOR EMMERGENCIES											
Existence of a functional ambulance or other vehicles for emergency transportation for clients											
Is fuel for the ambulance or other emergency vehicle available											
POWER SUPPLY											

Variables	Mulanda	Bufumbo	Aboke	Dokolo	Amolatar	Atiak	Padibe	Rugazi	Busanza	Karugutu	Bulisa
Access to electricity from any source (e.g. Electricity grid, generator, solar, or other)											
Existence of a secondary or back up source of electricity											
BASIC CLIENT AMENITIES											
Is the facility open 24 hours?											
Existence of a clean source of water at the facility premises											
Are there clean toilets (latrines) on the premises in a functioning condition that are accessible for general outpatient client use?											
INFECTION CONTROL											
Electric or Non-electric autoclave											
Electric dry heat sterilizer											
Electric boiler or steamer (N pressure)	-										
HEALTHCARE WASTE MANAGEMENT											
Does the facility have proper waste disposal facilities (incinerators, pit or protected ground, or sharps marked boxes)?											
GENERAL OUTPATIENTS SECTION											
BASIC EQUIPMENT											
Adult and child weighing scale											
Measuring tape-height board/stadiometer											
Thermometers											
Stethoscopes											
Blood pressure apparatus(maybe digital manual sphygmogram meter with a stethoscope)											
Intravenous infusion kits											

Variables	Mulanda	Bufumbo	Aboke	Dokolo	Amolatar	Atiak	Padibe	Rugazi	Busanza	Karugutu	Bulisa
Oxygen kits (concentrators and cylinders)											
MATERNITY SECTION											
Examination light (flashlight)											
Delivery pack											
Episiotomy scissors											
Scissors or blade to cut the cord											
Manual vacuum extractor											
Vacuum aspirator or D&C kit							-				
Incubator							-				
MALARIA											
Rapid diagnostic testing kits (RDTs)											
Microscopes											
Case management guidelines											
IPTP guidelines for pregnant women											
Accessibility of blood transfusion services											
Light microscope			-								-
Glass slides and coverslips											
Refrigerator		-	-								
Glucometer test strips (with valid expiration date)											-
Colorimeter or hemoglobin meter							-				
TUBERCULOSIS											
Case management guidelines											
Fluorescence microscope (FM)							-				

Variables	Mulanda	Bufumbo	Aboke	Dokolo	Amolatar	Atiak	Padibe	Rugazi	Busanza	Karugutu	Bulisa
ZIEL-Neelseen stain											-
Auramine Rhodamine stain for fluorescent microscopy							-				
Xpert MTB machine							-				
LIVER AND KIDNEY FUNCTION TESTING EQUIPMENT											
Biochemistry analyzer	-						-				
Centrifuge	-						-				-
Specific assay kits(s)-Liver function test	-						-				
Specific assay kits(s)-renal function test	-						-				
Hemoglobin analyzer (full blood count)	-						-				
HIV MANAGEMENT KITS											
Current HIV care and treatment guidelines											
CD4 counter/Machine											
Specific assay kit for CD4 tests											
Viral load testing equipment											-
Viral load testing kits											
HIV testing kits											
OTHER EQUIPMENT											
x-ray machine	-						-				
Ultrasound equipment	-						-				
CT scan	-						-				
ECG							-				

Health Center IV-Equipment

Variables	Bwijanga	Semuto	Bukomero	Kalagala
INPATIENT AND OBSERVATION BEDS				
Inpatient beds for adults and children				
Dedicated beds for maternity				
COMMUNICATION				
Existence of a functional cellular telephone or a private cellular phone				
Existence of a functional short-wave radio for radio calls.				
Existence of functional computer(s)				
Access to email or internet within the facility				
AMBULENCE/TRANSPORT FOR EMMERGENCIES				
Existence of a functional ambulance or other vehicles for emergency transportation for clients				
Is fuel for the ambulance or other emergency vehicle available?				
POWER SUPPLY				
Access to electricity from any source (e.g., electricity grid, generator, solar, or other)				
Existence of a secondary or back up source of electricity				
BASIC CLIENT AMENITIES				
Is the facility open 24 hours?				

Variables	Bwijanga	Semuto	Bukomero	Kalagala
Existence of a clean source of water at the facility premises?				
Is there a clean toilet (latrine) on the premises in a functioning condition that is accessible for general outpatient client use?				
INFECTION CONTROL				
Electric or Non-electric autoclave?				
Electric dry heat sterilizer				
Electric boiler or steamer (N pressure)				
HEALTHCARE WASTE MANAGEMENT				
Does the facility have proper waste disposal facilities (incinerators, pit or protected ground, sharps marked boxes)?				
GENERAL OUTPATIENTS SECTION				
BASIC EQUIPMENT				
Adult and child weighing scale				

Measuring tape-height board/stadiometer								
Thermometers								
Stethoscopes								
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)								
Intravenous infusion kits								
Oxygen kits (Concentrators and cylinders)								
MATERNITY SECTION								
Examination light (flashlight)								
Delivery pack								
Episiotomy scissors								
Scissors or blade to cut the cord								
Manual vacuum extractor								
Vacuum aspirator or D&C kit								
Incubator								
MALARIA								
Rapid diagnostic testing kits (RDTs)								
Microscopes								
Case management guidelines								
IPTP guidelines for pregnant women								
Accessibility of blood transfusion services								
Light microscope								
Glass slides and coverslips								
Refrigerator								
Glucometer test strips (with valid expiration date)						-		
Colorimeter or hemoglobin meter						-		

TUBERCULOSIS								
Case management guidelines								
Fluorescence microscope (FM)								
ZIEL-Neelseen stain								
Auramine Rhodamine stain for fluorescent microscopy						-		
Xpert MTB machine						-		
LIVER AND KIDNEY FUNCTION TESTING EQUIPMENT								
Biochemistry analyzer						-		
Centrifuge						-		
Specific assay kits(s)-Liver function test						-		
Specific assay kits(s)-Renal function test						-		
Hemoglobin analyzer (full blood count)						-		
HIV MANAGEMENT KITS								
Current HIV care and treatment guidelines								
CD4 counter/Machine								
Specific assay kit for CD4 tests								
Viral load testing equipment			N/A					
Viral load testing kits			N/A					
HIV testing kits								
OTHER EQUIPMENT								
X-ray machine						-		
Ultrasound equipment						-		
CT scan						-		
ECG						-		

Health Centre III-Equipment

Variables	Molo	Mudakori	Paya	Bumasikye	Buwangwa	Chesower	Kapkoloswo	Kortek	Riwo	Akalo	Bala	Amolydang	Okwongo	Barjobi
INPATIENT AND OBSERVATION BEDS														
Inpatient beds for adults and children										-				
Dedicated beds for maternity										-				
COMMUNICATION														
Existence of a functional cellular telephone or a private cellular phone														
Existence of a functional short-wave radio for radio calls														
Existence of functional computer(s)														
Access to email or internet within the facility														
AMBULENCE/TRANSPORT FOR EMMERGENCIES														
Existence of a functional ambulance or other vehicles for emergency transportation for clients														
Is fuel for the ambulance or other emergency vehicle available?														
POWER SUPPLY														
Access to electricity from any source (e.g. Electricity grid, generator, solar, or other)														
Existence of a secondary or back up source of electricity														
BASIC CLIENT AMENITIES														
Is the facility open 24 hours?														
Existence of a clean source of water at the facility premises														

Variables	Molo	Mudakori	Paya	Bumasikye	Buwangwa	Chesower	Kapkoloswo	Kortek	Riwo	Akalo	Bala	Amolydang	Okwongo	Barjobi
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?														
INFECTION CONTROL														
Electric or Non-electric autoclave														
Electric dry heat sterilizer														
HEALTHCARE WASTE MANAGEMENT														
Does the facility have proper waste disposal facilities (incinerators, pit or protected ground, sharps marked boxes)?														
GENERAL OUTPATIENTS SECTION														
BASIC EQUIPMENT														
Adult and child weighing scale														
Measuring tape-height board/ stadiometer														
Thermometers														
Stethoscopes											-			
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)														
Intravenous infusion kits														
MATERNITY SECTION														
Examination light (flashlight)														
Delivery pack														
Episiotomy scissors														
Scissors or blade to cut the cord														
Manual vacuum extractor														

Variables	Molo	Mudakori	Paya	Bumasikye	Buwangwa	Chesower	Kapkoloswo	Kortek	Riwo	Akalo	Bala	Amolydang	Okwongo	Barjobi
Vacuum aspirator or D&C kit														
MALARIA														
Rapid diagnostic testing kits (RDTs)														
Microscopes														
Case management guidelines														
IPTP guidelines for pregnant women														
Light microscope											-			
Glass slides and coverslips														
Refrigerator											-			
Glucometer test strips (with valid expiration date)											-			
TUBERCULOSIS														
Case management guidelines														
ZIEL-Neelseen stain														
HIV MANAGEMENT KITS														
Current HIV care and treatment guidelines														
CD4 counter/Machine		N/A				N/A		N/A						
Specific assay kit for CD4 tests		N/A				N/A		N/A						
Viral load testing kits		N/A				N/A		Y						
HIV testing kits														
ECG														

Health Center III-Equipment

Variables	Ollim	Omoro	Agwatta	Kangai	Kwera	Aputi	Etam	Namasale	Bibia
INPATIENT AND OBSERVATION BEDS									
Inpatient beds for adults and children									
Dedicated beds for maternity									
COMMUNICATION									
Existence of a functional cellular telephone or a private cellular phone									
Existence of a functional short-wave radio for radio calls									
Existence of functional computer(s)									
Access to email or internet within the facility									
AMBULENCE/TRANSPORT FOR EMMERGENCIES									
Existence of a functional ambulance or other vehicles for emergency transportation for clients									
Is fuel for the ambulance or other emergency vehicle available?									
POWER SUPPLY									
Access to electricity from any source (e.g. electricity grid, generator, solar, or other)?									
Existence of a secondary or back up source of electricity									
BASIC CLIENT AMENITIES									
Is the facility open 24 hours?									
Existence of a clean source of water at the facility premises									

Variables	Olilim	Omoro	Agwatta	Kangai	Kwera	Aputi	Etam	Namasale	Bibia
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?									
INFECTION CONTROL									
Electric or Non-electric autoclave?									
Electric dry heat sterilizer									
HEALTHCARE WASTE MANAGEMENT									
Does the facility have proper waste disposal facilities? (Incinerators, pit or protected ground, sharps marked boxes)?									
GENERAL OUTPATIENTS SECTION									
BASIC EQUIPMENT									
Adult and child weighing scale									
Measuring tape-height board/ stadiometer									
Thermometers									
Stethoscopes									
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)									
Intravenous infusion kits									
MATERNITY SECTION									
Examination light (flashlight)									
Delivery pack									
Episiotomy scissors									
Scissors or blade to cut the cord									
Manual vacuum extractor									
Vacuum aspirator or D&C kit									

Variables	Olilim	Omoro	Agwatta	Kangai	Kwera	Aputi	Etam	Namasale	Bibia
MALARIA									
Rapid diagnostic testing kits (RDTs)									
Microscopes									
Case management guidelines									
IPTP guidelines for pregnant women									
Light microscope									
Glass slides and cover lips									
Refrigerator									
Glucometer test strips (with valid expiration date)									
TUBERCULOSIS									
Case management guidelines									
ZIEL-Neelseen stain									
HIV MANAGEMENT KITS									
Current HIV care and treatment guidelines									
CD4 counter/Machine									
Specific assay kit for CD4 tests									
Viral load testing kits									
HIV testing kits									
ECG									

Health Center III-Equipment

Variables	Pawel	Pogo	Laguti	Puranga	Awere	Padibe West	Palongo	Katunguru	Katerera	Nyarubuye	Nyarusiza	Ntoroko
INPATIENT AND OBSERVATION BEDS												
Inpatient beds for adults and children												
Dedicated beds for maternity												
COMMUNICATION												
Existence of a functional cellular telephone or a private cellular phone												
Existence of a functional short-wave radio for radio calls												
Existence of functional computer(s)												
Access to email or internet within the facility												
AMBULENCE/TRANSPORT FOR EMMERGENCIES												
Existence of a functional ambulance or other vehicles for emergency transportation for clients												
Is fuel for the ambulance or other emergency vehicle available?												
POWER SUPPLY												
Access to electricity from any source (e.g. electricity grid, generator, solar, or other)												
Existence of a secondary or back up source of electricity												
BASIC CLIENT AMENITIES												
Is the facility open 24 hours?												
Existence of a clean source of water at the facility premises?												
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?												

Variables	Pawel	Pogo	Laguti	Puranga	Awere	Padibe West	Palongo	Katunguru	Katerera	Nyarubuye	Nyarusiza	Ntoroko
INFECTION CONTROL												
Electric or Non-electric autoclave?							-					
Electric dry heat sterilizer							-					
HEALTHCARE WASTE MANAGEMENT												
Does the facility have proper waste disposal facilities? (Incinerators, pit or protected ground, sharps marked boxes)?												
GENERAL OUTPATIENTS SECTION												
BASIC EQUIPMENT												
Adult and child weighing scale												
Measuring tape-height board/ stadiometer												
Thermometers												
Stethoscopes												
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)												
Intravenous infusion kits												
MATERNITY SECTION												
Examination light (flashlight)												
Delivery pack												
Episiotomy scissors												
Scissors or blade to cut the cord												
Manual vacuum extractor												
Vacuum aspirator or D&C kit												
MALARIA												

Variables	Pawel	Pogo	Laguti	Puranga	Awere	Padibe West	Palongo	Katunguru	Katerera	Nyarubuye	Nyarusiza	Ntoroko
Rapid diagnostic testing kits (RDTs)												
Microscopes												
Case management guidelines												
IPTP guidelines for pregnant women												
Light microscope											-	
Glass slides and cover lips												
Refrigerator												
Glucometer test strips (with valid expiration date)												
TUBERCULOSIS												
Case management guidelines												
ZIEL-Neelseen stain												
HIV MANAGEMENT KITS												
Current HIV care and treatment guidelines												_
CD4 counter/Machine												-
Specific assay kit for CD4 tests												-
Viral load testing kits												-
HIV testing kits												-
ECG												

Health Center III-Equipment

Variables	Buhanuka	Butema	Karongo	Avogra	Butiaba	Biiso	Kimengo	Kyatiri	Kikamulo	Kapeeka	Kalungi	Muwanga
INPATIENT AND OBSERVATION BEDS												
Inpatient beds for adults and children												
Dedicated beds for maternity								-				
COMMUNICATION												
Existence of a functional cellular telephone or a private cellular phone												
Existence of a functional short-wave radio for radio calls												
Existence of functional computer(s)?												
Access to email or internet within the facility												
AMBULENCE/TRANSPORT FOR EMMERGENCIES												
Existence of a functional ambulance or another vehicle for emergency transportation for clients												
Is fuel for the ambulance or other emergency vehicle available?												
POWER SUPPLY												
Access to electricity from any source (e.g. electricity grid, generator, solar, or other)?												
Existence of a secondary or back up source of electricity								-				
BASIC CLIENT AMENITIES												
Is the facility open 24 hours?												
Existence of a clean source of water at the facility premises?												
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?												

Variables	Buhanuka	Butema	Karongo	Avogra	Butiaba	Biiso	Kimengo	Kyatiri	Kikamulo	Kapeeka	Kalungi	Muwanga
INFECTION CONTROL												
Electric or Non-electric autoclave?												
Electric dry heat sterilizer												
HEALTHCARE WASTE MANAGEMENT												
Does the facility have proper waste disposal facilities? (Incinerators, pit or protected ground, sharps marked boxes)?												
GENERAL OUTPATIENTS SECTION												
BASIC EQUIPMENT												
Adult and child weighing scale												
Measuring tape-height board/ stadiometer												
Thermometers												
Stethoscopes												
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)												
Intravenous infusion kits												
MATERNITY SECTION												
Examination light (flashlight)												
Delivery pack												
Episiotomy scissors												
Scissors or blade to cut the cord												
Manual vacuum extractor												
Vacuum aspirator or D&C kit												
MALARIA												

Variables	Buhanuka	Butema	Karongo	Avogra	Butiaba	Biiso	Kimengo	Kyatiri	Kikamulo	Kapeeka	Kalungi	Muwanga
Rapid diagnostic testing kits (RDTs)												
Microscopes												
Case management guidelines												
IPTP guidelines for pregnant women												
Light microscope												
Glass slides and cover lips												-
Refrigerator												
Glucometer test strips (with valid expiration date)												
TUBERCULOSIS												
Case management guidelines												
ZIEL-Neelseen stain												
HIV MANAGEMENT KITS												
Current HIV care and treatment guidelines												
CD4 counter/Machine												
Specific assay kit for CD4 tests												
Viral load testing kits												
HIV testing kits												
ECG												

Health Center III-Equipment

Variables	Kambugu	Bamananika	Isunga	Mpeefu B	Butemba	Kiyuni	Kisubi	Najjemba
INPATIENT AND OBSERVATION BEDS								
Dedicated beds for maternity								
COMMUNICATION								
Existence of a functional cellular telephone or a private cellular phone								
Existence of a functional short-wave radio for radio calls								
Existence of functional computer(s)								
Access to email or internet within the facility								
AMBULENCE/TRANSPORT FOR EMMERGENCIES								
Existence of a functional ambulance or other vehicles for emergency transportation for clients								
Is fuel for the ambulance or other emergency vehicle available?								
POWER SUPPLY								
Access to electricity from any source (e.g. electricity grid, generator, solar, or other)								
Existence of a secondary or back up source of electricity								
BASIC CLIENT AMENITIES								
Is the facility open 24 hours?								
Existence of a clean source of water at the facility premises?								
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?								
INFECTION CONTROL								
Electric or Non-electric autoclave								

Variables	Kambugu	Bamananika	Isunga	Mpeefu B	Butemba	Kiyuni	Kisubi	Najjemba
Electric dry heat sterilizer								
HEALTHCARE WASTE MANAGEMENT								
Does the facility have proper waste disposal facilities? (Incinerators, pit or protected ground, sharps marked boxes)?								
GENERAL OUTPATIENTS SECTION								
BASIC EQUIPMENT								
Adult and child weighing scale								
Measuring tape-height board/ stadiometer								
Thermometers								
Stethoscopes								
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)								
Intravenous infusion kits								
MATERNITY SECTION								
Examination light (flashlight)								
Delivery pack								
Episiotomy scissors								
Scissors or blade to cut the cord								
Manual vacuum extractor								
Vacuum aspirator or D&C kit								
MALARIA								
Rapid diagnostic testing kits (RDTs)								
Microscopes								

Variables	Kambugu	Bamananika	Isunga	Mpeefu B	Butemba	Kiyuni	Kisubi	Najjemba
Case management guidelines								
IPTP guidelines for pregnant women								
Light microscope								
Glass slides and cover lips								
Refrigerator								
Glucometer test strips (with valid expiration date)								
TUBERCULOSIS								
Case management guidelines								
ZIEL-Neelseen stain								
HIV MANAGEMENT KITS								
Current HIV care and treatment guidelines								
CD4 counter/Machine								
Specific assay kit for CD4 tests								
Viral load testing kits								
HIV testing kits								
ECG								

Health Center III-Equipment

Variables	Wakisi	Lukale	Buyaga	Namatale	Nazigo
INPATIENT AND OBSERVATION BEDS					
Inpatient beds for adults and children					
Dedicated beds for maternity					
COMMUNICATION					
Existence of a functional cellular telephone or a private cellular phone					
Existence of a functional short-wave radio for radio calls					
Existence of functional computer(s)					
Access to email or internet within the facility					
AMBULENCE/TRANSPORT FOR EMMERGENCIES					
Existence of a functional ambulance or other vehicles for emergency transportation for clients					
Is fuel for the ambulance or other emergency vehicle available?					
POWER SUPPLY					
Access to electricity from any source (e.g. Electricity grid, generator, solar, or other)?					
Existence of a secondary or back up source of electricity					
BASIC CLIENT AMENITIES					
Is the facility open 24 hours?					
Existence of a clean source of water at the facility premises?					
Is there a clean toilet (Latrine) on the premises in a functioning condition that is accessible for general outpatient client use?					
INFECTION CONTROL					

Variables	Wakisi	Lukale	Buyaga	Namatale	Nazigo
Electric or Non-electric autoclave					
Electric dry heat sterilizer					
HEALTHCARE WASTE MANAGEMENT					
Does the facility have proper waste disposal facilities? (Incinerators, pit or protected ground, sharps marked boxes)?					
GENERAL OUTPATIENTS SECTION					
BASIC EQUIPMENT					
Adult and child weighing scale					
Measuring tape-height board/ stadiometer					
Thermometers					
Stethoscopes					
Blood pressure apparatus (maybe digital manual sphygmogram meter with a stethoscope)					
Intravenous infusion kits					
MATERNITY SECTION					
Examination light (flashlight)					
Delivery pack					
Episiotomy scissors					
Scissors or blade to cut the cord					
Manual vacuum extractor					
Vacuum aspirator or D&C kit					
MALARIA					
Rapid diagnostic testing kits (RDTs)					
Microscopes					

Variables	Wakisi	Lukale	Buyaga	Namatale	Nazigo
Case management guidelines					
IPTP guidelines for pregnant women					
Light microscope					
Glass slides and cover lips					
Refrigerator					
Glucometer test strips (with valid expiration date)			-		
TUBERCULOSIS					
Case management guidelines					
ZIEL-Neelseen stain					
HIV MANAGEMENT KITS					
Current HIV care and treatment guidelines					
CD4 counter/Machine					
Specific assay kit for CD4 tests					
Viral load testing kits					
HIV testing kits					
ECG					

Appendix II: INPUT TRACKING TOOLS-STAFFING STATUS

Staffing levels for health Center IVs

Variables	Orum			Dokolo			Amolatar			Atiak				
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap		
Sen. Medical Officer	1	1	0	1	0	1	1	1	0	1	1	0		
Medical Officer	1	1	0	1	2	+1	1	1	0	1	1	0		
Senior Nursing Officer	1	0	1	1	1	0	1	0	1	1	2	1		
Public Health Nurse	1	0	1	1	1	0	1	1	0	1	0	1		
Clinical Officer	2	2	0	2	2	0	5	4	1	3	2	1		
Ophthalmic Clinical Officer	1	2	1	1	0	1	1	0	1	1	0	0		
Health Inspector	2	1	1	1	0	1	1	2	1	1	1	0		
Dispenser	1	0	1	1	1	0	1	0	1	1	0	1		
Public Health Dental Officer	1	0	1	1	1	0	1	1	0	1	1	0		
Lab. Technician		1		1	3	+2	1	1	0	1	1	0		
Ass. Entomological Officer	1	1	0	1	1	0	1	1	0	1	0	1		
Nursing Officer (Nursing)	1	1	0	1	1	0	1	1	0	3	2	1		
Nursing Officer (Mid-Wifely)	1	1	0	1	1	0	1	1	0	1	1	0		
Nursing Officer (Psychiatry)	1	1	0	1	1	0	1	0	1	1				
Ass. Health Educator	1	0	1	1	1	0	1	0	1	1	0	1		
Anesthetic Officer	1	1	1	1	0	1	1	0	1	1	1	0		
Theatre Assistant	2	2	0	2	1	1	2	1	1	2				
Enrolled Psychiatric Nurse	1	1	0	1	1	0	1	1	1	1	1	0		

Enrolled Nurse	3	4	0	3	4	+1	3	5	+2	3	3	0		
Enrolled Mid-Wife	3	3	0	6	3	3	3	4	+1	3	1	2		
Cold Chain Assistant	1	0	1	1	1	0	1	0	1	1	0	1		
Office Typist	1	0	1	1	1	0	1	1	0	1	0	1		
Lab. Assistant	1	1	0	2	1	1	1	1	0	2	2	0		
Stores Assistant	1	0	1	1	0	1	1	1	0	1	0	1		
Accounts Assistant	1	0	1	1	1	0	1	1	0	1	0	1		
Health Assistant	1	0	1	1	0	1	1	0	1	1	1	0		
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0		
Nursing Assistant	5	0	5	5	4	1	3	5	+2	5	4	1		
Driver	1	1	0	2	1	1	1	1	0	2	2	0		
Guard	3	3	0	4	3	1	2	2	0	3	3	0		
Porter	5	3	2	4	3	1	3	2	1	3	2	1		
% Staffing			**68.1%**			**78.8%**			**88.9%**			**66.0%**		

Staffing levels for Health Centre IVs

Variables	Padibe			Rugazi			Busanza			Karugutu			Bulisa			Bwijanga		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Sen. Medical Officer	1	0	1	1	1	0	0	0	0	1	0	1	1	1	0	1	1	0
Medical Officer	1	2	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Senior Nursing Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1
Public Health Nurse	1	0	1	1	1	0	1	1	0				1	0	1	1	0	1
Clinical Officer	1	1	0	2	1	1	2	1	1	2	2	0	2	3	1	2	1	1
Ophthalmic Clinical Officer	1	1	0	2	1	1				1	0	0	1	0	1	1	0	1
Health Inspector	2	2	0	2	1	1	1	1	0	1	1	0	1	0	1	2	2	0
Dispenser	1	0	1	1	1	0				1	1	0	1	1	0	1	1	0
Public Health Dental Officer	1	1	0	1	1	0	1	1	0	2	1	1	1	2	+1	1	1	0
Lab. Technician	1	2	1	2	2	0	1	1	0	1	1	0	2	1	1	1	1	0
Ass. Entomological Officer	1	1	0	1	0	1				1	0	1	1	1	0	1	1	0
Nursing Officer	1	1	0	1		0	1	1	0	1	1		3	2		1	1	

(Nursing)					1							0			1			0
Nursing Officer (Mid-Wifely)	1	1	0	2	2	0	1	1	0	1	1	0	1	2	+1	1	1	0
Nursing Officer (Psychiatry)	1	1	0	1	0	1				1	1	0	1	1	0	1	1	0
Ass. Health Educator	1	1	0	1	1	0				1	0	1	1	1	0	1	0	1
Anesthetics Officer	1	1	0	1	1	0				1	1	0	1	0	1	1	1	0
Theatre Assistant	2	1	1	2	1	1				2	1	1	3	0	3	2	1	1
Enrolled Psychiatric Nurse	1	1	0	1	0	1				1	1	0	1	1	0	1	2	+1
Enrolled Nurse	3	3	0	3	6	+3	3	3	0				8	11	+3	4	4	0
Enrolled Mid-Wife	3	3	0	3	4	+1	3	3	0	3	4	+1	4	6	+2	2	3	+1
Cold Chain Assistant	1	1	0	1	0	1				1	1	0	1	1	0	1	1	0
Office Typist	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0	1	0	1
Lab. Assistant	1	1	0	1	2	+1	1	1	0	1	1	0	1	2	1	1	1	0
Stores Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1
Accounts Assistant	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1
Health Assistant	1	1	0	1	1	0				1	1	0	1	1	0	1	1	0
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Assistant	5	3	2	5	0	5				3	3	0	3	3	0	5	1	4
Driver	2	1	1	1	1	0	1	1	0	1	1	0	1	2	+1	1	1	0
Guard	2	2	0	3	1	2	2	2	0	3	2	1	2	1	1	3	2	1
Porter	4	0	4	3	3	0	2	2	0	3	3	0	5	4	1	3	4	+1

%Staffing rate	**78.3%**	**79.9%**	**96.2%**	**82.5%**	**96.3%**	**76.1%**

Staffing levels for health Center IVs

Variables	Semuto			Bukomero			Kalagala		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Sen. Medical Officer	1	1	0	1	0	1	1	0	1
Medical Officer	1	1	0	2	2	0	1	2	+1
Senior Nursing Officer	1	1	0	1	1	0	1	1	0
Public Health Nurse	1	0	1	1	1	0	1	0	1
Clinical Officer	2	0	2	2	4	+2	2	2	0
Ophthalmic Clinical Officer	1	1	0	1	1	0	1	0	1
Health Inspector	2	1	1				2	1	1
Dispenser	1	0	1	1	0	1	1	1	0
Public Health Dental Officer	1	1	0	1	0	1	1	1	0
Lab. Technician	1	1	0	1	2	1	1	2	+1
Ass. Entomological Officer	1	1	0	1	0	1	1	1	1
Nursing Officer (Nursing)	1	3	+2	1	1	0	1	0	1
Nursing Officer (Mid-Wifely)	1	2	+1	1	1	0	1	3	+2
Nursing Officer (Psychiatry)	1	0	1	1	0	1	1	3	+2
Ass. Health Educator	1	0	1	1	1	0	1	1	0
Anesthetic Officer	1	0	1	1	1	0	1	2	1
Theatre Assistant	2	2	0	2	1	1	2	2	0
Enrolled Psychiatric Nurse	1	1	0	1	1	0	1	0	1
Enrolled Nurse	3	6	+3	3	6	+3	3	4	+1
Enrolled Mid-Wife	3	4	+1	3	6	+3	3	3	0

Cold Chain Assistant	1	0	1	1	1	0	1	1	0
Office Typist	1	0	1				1	1	0
Lab. Assistant	1	3	+2	1	0	1	1		0
Stores Assistant	1	1	0	1	1	0	1	1	0
Accounts Assistant	1	0	1	1	1	0	1	1	0
Health Assistant	1	1	0	1	1	0	1	2	+1
Health Information Assistant	1	1	0	1	1	0	1	2	+1
Nursing Assistant	5	4	1	1	1	0	5	5	0
Driver	1	1	0	1	1	0	1	0	1
Guard	3	3	0	3	2	1	3	0	3
Porter	3	2	1	3	4	+1	3	0	3
% Staffing Levels			**91.3%**			**105%**			**91.3%**

Staffing levels for Health Center IIIs

Variables	Molo			Mudakori			Paya			Chesower			
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap		Norm	Actual	Gap
Senior Clinical Officer	1	1	0	1	1	0	1	1	0		1	1	0
Clinical Officer	1	1	0	1	1	0	1	0	1		1	1	0
Lab. Technician	1	1	0	1	1	0	1	1	0		1	0	0
Nursing Officer (Nursing)	1	1	0	2	1	1	3	2	1		1	1	0
Enrolled Nurse	3	3	0	4	2	2	3	0	3		1	1	0
Enrolled Mid-Wife	2	2	0	3	2	1	1	1	0		2	2	0
Health Assistant	1	1	0	1	1	0	2	1	1		1	1	0
Lab. Assistant	1	1	0	1	1	0	1	0	1		2	1	1
Health Information Assistant	1	1	0	1	1	0	1	0	1		1	1	0
Nursing Assistant	3	1	2	1	1	0	1	1	0		1	0	1
Driver													
Guard	1	1	0	1	1	0	1	1	0		2	1	1
Porter	2	0	2	2	1	1	3	2	1		2	1	1
%Staffing Levels			**77.8%**			**73.7%**			**52.6%**				**68.8%**

Staffing levels for Health Center IIIs

Variables	Health Center IIIs																				
	Kapkoloswo			Kortek			Riwo			Akalo			Bala			Amoladyang			Okwongo		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	0	1	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1	1	0	1
Clinical Officer	1	1	0	1	1	0	1	0	1	1	0	0	1	1	0	1	1	0	1	1	0
Lab. Technician	1	0	1	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1	1	1	0
Nursing Officer (Nursing)	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	2	0	2	1	1	0
Enrolled Nurse	3	1	2	2	1	1	2	2	0	3	0	3	3	1	2	3	0	3	3	2	1
Enrolled Mid-Wife	2	1	1	2	1	1	2	1	1	3	3	0	3	1	2	3	1	2	2	2	0
Health Assistant	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0
Lab. Assistant	1	2	+1	2	2	0	2	0	2	1	1	0	1	1	0	1	0	1	1	1	0
Health Information Assistant	1	1	0	1	1	0	1	0	1	1	1	0	1	0	1	1	0	1	1	1	0
Nursing Assistant	3	0	3	2	1	1	3	1	2	2	2	0	2	1	1	3	1	2	2	1	1
Driver				1	0	1										1	0	1	0	0	0
Guard	2	1	1	2	1	1	2	0	2	2	2	0	2	1	1	2	0	2	2	2	0
Porter	2	2	0	2	1	1	2	0	2	2	2	0	2	1	1	2	1	1	2	1	1
%Staffing			**57.9%**			**52.6%**			**26.3%**			**78.9%**			**57.9%**			**18.2%**			**77.8%**

Levels							

Staffing levels for Health Center IIIs

Variables	Barjobi			Agwatta			Kangai			Kwera		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	0	1	1	0	1	1	1	0	1	0	1
Clinical Officer	2	1	1	1	2	+1	1	1	0	1	2	1
Lab. Technician	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Officer (Nursing)	1	1	0	1	1	0	1	0	1	1	1	0
Enrolled Nurse	3	1	2	3	4	+1	3	1	2	3	4	+1
Enrolled Mid-Wife	2	2	0	6	3	3	2	2	0	6	3	3
Health Assistant	1	1	0	1	0	1	1	1	0	1	0	1
Lab. Assistant	1	1	0	2	1	1	1	0	1	2	1	1
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Assistant	1	1	0	3	4	+1	3	3	0	3	4	+1
Driver	1	0	1	2	1	1				2	1	1
Guard	2	2	0	4	3	1	2	2	0	4	3	1
Porter	2	1	1	4	3	1	2	1	1			
%Staffing Levels			**68.4%**			**80%**			**73.7%**			**80%**

Staffing levels for Health Center IIIs

Variables	Bibia			Pawel			Pogo			Laguti			Puranga			Awere		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0
Clinical Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1
Lab. Technician	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	1	0
Nursing Officer (Nursing)	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0
Enrolled Nurse	3	3	0	3	2	1	2	2	0	4	4	0	2	2	0	3	1	2
Enrolled Mid-Wife	2	2	0	2	2	0	2	2	0	2	2	0	3	2	1	3	2	1
Health Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Lab. Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Assistant	2	2	0	2	3	+1	2	1	1	3	2	1	2	2	0	3	1	2
Driver	1	1	0	1	0	1	1	0	1	1	0	1	1	0	0	1	0	1
Guard	2	2	0	2	2	0	2	1	1	2	1	1	2	1	1	2	1	1
Porter	2	1	1				2	2	0	1	0	1	2	1	1	2	1	1
%Staffing Levels			**94.7%**			**88.2%**			**72.2%**			**70%**			**68.4%**			**57.1%**

Staffing levels for Health Center IIIs

Variables	Health Center IIIs																				
	Padibe West			Palabek-Kal			Palebek Ogili			Katunguru			Katerera			Nyarusiza			Karongo		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Clinical Officer	0	0	-	0	1	+1	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1
Lab. Technician	0	0	-	0	1	+1	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1
Nursing Officer (Nursing)	1	1	0	1	1	0	1	0	1	1	1	0	1	O	1	1	1	0	1	0	1
Enrolled Nurse	3	2	1	2	2	0	2	2	0	2	2	0	3	4	+1	4	3	1	3	2	1
Enrolled Mid-Wife	3	2	1	2	2	0	2	2	0	2	1	1	2	2	0	4	3	1	3	3	0
Health Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0	1	0	1
Lab. Assistant	1	1	0	0	1	+1	1	0	1	1	0	1	1	0	1	1	1	0	1	1	0
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Assistant	3	1	2	1	2	1	3	1	1	3	1	2	3	1	2	2	2	-	3	1	2
Driver	0	0	-	-	-		1	0	1	1	0	1							1	0	1
Guard	0	0	-	1	2	1	2	1	1	2	1	1	2	1	1	1	2	1	2	1	1
Porter	0	0	-	-	-		2	2	0	2	0	0	2	1	1	2	2	0	2	1	1
%Staffing Levels	**71.4%**			**150%**			**63.2%**			**52.6%**			**68.4%**			**95%**			**52.4%**		

Staffing levels for Health Center IIIs

Variables	Health Center IIIs																				
	Butiaba			Biiso			Kimengo						Kyatiri			Kapeeka			Mifunya		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	0	1	1	1	0	1	0	1	1	0	1	1	O	1	1	1	0	1	0	1
Clinical Officer	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	2	0	2
Lab. Technician	1	1	0	1	1	0	2	2	0	1	1	0	2	1	1	2	1	1	1	0	1
Nursing Officer (Nursing)	1	1	0	1	1	0	1	0	1	1	1	1	1	1	0	2	2	0	1	0	1
Enrolled Nurse	3	5	+2	2	5	+3	3	2	1	5	5	0	4	4	0	4	4	0	2	2	0
Enrolled Mid-Wife	2	5	+3	2	5	+3	3	2	1	2	3	0	2	1	1	4	4	0	2	1	1
Health Assistant	1	1	0	0	1	+1				1	1	0	1	1	0	1	1	0	1	1	0
Lab. Assistant	1	0	1	1	1	0	2	2	0	1	1	0	1	0	1	2	2	0	2	0	2
Health Information Assistant	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1
Nursing Assistant	2	0	2	3	2	+1	1	2	1	2	0	2	3	1	2	2	2	0	2	2	0
Driver	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	1	0	1	1	0	1
Guard	2	1	1	1	1	0	2	2	0	2	2	0	2	2	0	2	1	1	2	1	1
Porter	2	3	1	2	3	0	2	1	1	2	2	0	2	2	0	2	1	1	1	1	0
%Staffing Levels	**100%**			**143.8%**			**73.7%**			85.7%			68.2%			**84%**			**42.1%**		

Staffing levels for Health Center IIIs

Variables	Health Center IIIs																				
	Kalungi			Nabiswera			Kambugu			Bamunanika			Isunga			Mpeefu B			Butemba		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	0	1	1	2	0
Clinical Officer	1	1	0	1	1	0	2	2	0	1	1	0	1	2	1	2	2	0	1	2	0
Lab. Technician	1	1	0	1	1	0	-	-	-	1	1	0	1	1	0	2	1	1	1	4	0
Nursing Officer (Nursing)	3	0	3	3	2	1	1	1	0	1	3	+2	1	1	0	1	0	1	1	2	0
Enrolled Nurse	2	4	+2	2	1	1	3	5	+2	3	2	1	4	2	+2	8	8	0	3	2	1
Enrolled Mid-Wife	3	2	1	3	2	1	3	2	1	2	1	1	3	3	0	4	4	0	2	3	0
Health Assistant	1	1	0	1	1	0	1	1	0	1		0	1	1	0	1	1	0	1	1	0
Lab. Assistant	1	1	0	1	1	0	2	2	0	1	1	1	1	1	0	1	1	0	1	1	0
Health Information Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Nursing Assistant	2	1	1	2	2	0	3	1	2	2	2	0	2	3	1	2	0	2	3	1	2
Driver	1	1	0	1	1	0	0	0	0	0	0	1	1	0	1	2	0	2	0	0	0
Guard	2	1	1	2	2	0	2	1	1	2	2	0	2	1	0	2	1	1	2	1	1
Porter	2	1	1	2	3	1	2	2	0	2	2	2	1	1	0	1	0	1	2	2	0
% Staffing Levels			**76.2%**			**85.7%**			**85.7%**			**100%**			**85%**			**67.9%**			**115%**

Staffing levels for Health Center IIIs

Variables	Najjemba			Bugaya			Namatale		
	Norm	Actual	Gap	Norm	Actual	Gap	Norm	Actual	Gap
Senior Clinical Officer	1	0	1	2	0	2	1	0	1
Clinical Officer	1	1	0	2	1	1	1	1	1
Lab. Technician	1	1	0	2	1	1	1	1	0
Nursing Officer (Nursing)	1	1	0	2	0	2	1	1	0
Enrolled Nurse	3	3	0	2	0	2	3	1	2
Enrolled Mid-Wife	3	2	1	2	1	1	2	1	1
Health Assistant	1	1	0	1	1		1	1	0
Lab. Assistant	1	0	1	1	0	1	1	1	0
Health Information Assistant	1	1	0	1	1		1	0	1
Nursing Assistant	2	1	1	2	1	1	2	2	0
Driver	1	0	1						
Guard	2	1	1	1	1		2	1	1
Porter	2	1	1	2	1	1			
% Staffing Levels			65%			40%			66.7%

Appendix III: Community Scorecard in Pictures

Bumasikye HC III, Mbale District

Busano HC III, Mbale District

Patient and Health Workers Toilet at Bumasikye HC III, Mbale District

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Infant and Young Child Feeding Recommendations in Ebola Context

KEY FACTS ABOUT EBOLA TRANSMISSION

- Ebola can be transmitted via body fluids, including **breast milk.**
- A breastfeeding mother with symptoms of Ebola, increases the risk of transmission to the baby.
- Although replacement feeding with breast milk substitutes has high risks of morbidity and mortality, the safest feeding option for infants less than 6 months of age in the context of Ebola is ready-to-use infant formula (RUIF).
  - Wet nursing is not recommended.

IYCF Recommendations in the Ebola context

Asymptomatic infant less than 6 months of age + Confirmed Ebola infected mother

- Isolate the mother from the child.
- Start replacement feeding with RUIF
- Give psychosocial support to child and mother

Confirmed Ebola infected infant less than six months of age + Confirmed Ebola infected mother

- Support mother to continue breastfeeding if she is able to do so
- Replacement feeding with RUIF, if mother not able to do so
- Give psychosocial support to child and mother

Asymptomatic child 6 –12 months of age + Confirmed Ebola infected mother

- Separate the mother from the child
- Complementary foods, including animal milk or preferably RUIF
- Give psychosocial support to child and mother

Confirmed Ebola infected infant over 12 months + infected mother

- Support mother to continue breastfeeding if she is able to do so.
- Complementary foods, including animal milk
- Give psychosocial support to child and mother.

IYCF after recovery from Ebola

IEC Materials at Busano HC III, Mbale District

Maternity Ward, Kakamulo HC III, Nakaseke District

Children's Ward, Semuto HIV, Nakaseke District

Health Workers' Houses, Semuto HIV, Nakaseke District

IEC Materials at Probation Officer's Office, Mbale District

MINISTRY OF HEALTH

Treatment regimen for a child who is diagnosed with TB

Type of TB disease	Regimen	
	Intensive Phase	Continuation Phase
All forms of TB (excluding TB meningitis and Bone TB)	2RHZE	4RH
TB meningitis Bone (Osteoarticular) TB	2RHZE	10RH

* Ethambutol is safe for use in children provided the dose is within the recommended range
* Streptomycin is no longer recommended for use in the treatment of drug susceptible TB
* Children with TB meningitis or airway obstruction due to TB adenopathy should receive steroids in addition to TB treatment (e.g. prednisolone at 2mg/kg/day for 4 weeks and then gradually reduced over 1 - 2 weeks)
* Children diagnosed with drug resistant TB should be referred to the nearest MDR TB treatment site for further management

Dosage of Anti-TB medicines by weight band

IEC Materials at Rubirize HC IV, Rubirizi District

Washrooms, Maternity Ward, Kikamulo HC III, Nakaseke District

Patients' Toilets, Semuto HCIV, Nakaseke District

Appendix IV: References

1. Uganda AIDS Commission: National Strategic Plan (2015/16 – 2019,
2. Uganda AIDS Commission and Ministry of Health: The National HIV and AIDS Monitoring & Evaluation Plan 2014/2015-2019/2020 of the Strategic HIV and AIDS Plan, April 2015
3. UNASO: Uganda AIDS Accountability Score Card, February 2014
4. UNASO: An Assessment of Governance and Accountability Mechanisms in HIV/AIDS Control in Uganda, March 2013
5. CARE Malawi: "The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services. Cooperative for Assistance and Relief Everywhere, Inc., 2013.
6. Department of State for Finance and Economic Affairs (DOSFEA), Operational Manual for Community Based Performance Monitoring, Banjul The Gambia, January 2004
7. Ministry of Finance Planning and Economic Development: Millennium Development
8. Protection of Basic Services (PBS), Piloting Social Accountability in Ethiopia Booklet.
9. Radford A, Pink G, Ricketts T, Spade J. A Comparative Performance Scorecard for Federally Funded Community Health Centers in North Carolina. *Journal of Healthcare Management*. 2007; 52: 20 - 33
10. The World Bank, The Community Scorecard Process – Introducing the Concept and Methodology
11. Uganda Bureau of Statistics (2014) 'National Population and Housing Census, UBOS: Kampala
12. Uganda Bureau of Statistics (2016) 'Demographic and Health Survey Report", UBOS: Kampala
13. Kadowa Isaac, Ministry of Health, Uganda (2017) "A case study of the Uganda National Minimum Healthcare Package"
14. Ministry of Health (2019) "Uganda Master Health Facility List 2018" MOH, Kampala
15. Ministry of Health (2017) "Human Resource for Health Audit Report" MOH, Kampala
16. Ministry of Health (2014) "Uganda Hospital and Health Centre IV Census Survey" MOH, Kampala
17. AIDS Support Organization (TASO) Uganda Ltd (2018) "Report for Community Scorecard (CSC) for Community Monitoring of Health service delivery"
18. Ministry of Health: The National Tuberculosis and Leprosy Control Programme, Revised National Strategic Plan, 2015/16-2019/20, June 2017
19. Ministry of Health: The Uganda Malaria Reduction Strategic plan 2014-2020, May 2014

Appendix V: Community Scorecard Assessment Tools

Interface Meeting HIV Service Delivery

Name of facility:	**Level:**	**Parish:**
Sub-county:	**District:**	**Category of Clients:**

S.NO	PERFORMANCE CRITERIA	Beneficiaries' (Men) Score	Beneficiaries' (Women) Score	Service Provider's Score	Combined Score	Reason for Score	Recommendation
1.0	**HIV PREVENTION**						
1.1	Quality and availability of eMTCT Services						
1.2	Quality of Voluntary Medical Male Circumcision services						
1.3	Availability of Condom (Male and Female condoms)						
1.4	HIV Testing and Counselling services						
1.5	Availability and accessibility of PEP services						
1.6	Availability and accessibility of PrEP services						
1.7	Availability and access to condom compatible lubricants						

1.8	Provision of Information, Education and Communication/ Behavior Change Communication (IEC/BCC) for HIV and AIDS Prevention						
2.0	**CARE AND TREATMENT**						
2.1	Access to ART for Adults						
2.2	Availability and access to Pediatric HIV Care						
2.3	Access to Adolescent HIV Treatment						
2.4	Availability of other diagnostics and medicines for HIV management (OIs)						
2.5	Integrated services for HIV, TB, RMNCAH, STI at all centers						
2.6	Availability of Viral load monitoring services						
2.7	Mechanisms for community level follow-up and treatment support for adult and children PLHIV						
3.0	**SOCIAL SUPPORT & PROTECTION**						
3.1	Rights awareness and Support						

3.2	Availability of Legal support and social services						
3.3	Sexual and Gender Based Violence						
3.4	PEP kits and emergency contraceptives available						
3.5	Service providers skilled and trained in GBV/SGBV and violence against children						
3.6	Functionality of referral system for SGBV cases						

Interface Meeting TB services delivery

Name of the facility:	**Level:**	**Parish:**
Sub-county:	**District:**	**Category of Clients:**

S.NO	PERFORMANCE CRITERIA	Beneficiaries' (Men) SCORE	Beneficiaries' (Women) SCORE	Service Providers SCORE	Combined Score	REASON FOR SCORE	RECOMMENDATION
1.0	**Case notification and identification**						
1.1	Availability of qualified staff to screen and diagnose TB						
1.2	TB care and prevention integrated into other healthcare service delivery interventions						

S.NO	PERFORMANCE CRITERIA	Beneficiaries' (Men) SCORE	Beneficiaries' (Women) SCORE	Service Providers SCORE	Combined Score	REASON FOR SCORE	RECOMMENDATION
1.3	Availability of TB screening and testing equipment						
1.4	Availability of facility - community linkages for TB services (Client/defaulter tracing)						
2.0	**TB infection control practices**						
2.1	Availability of IPT services among PLHIV to those without TB						
2.2	Availability of TB/HIV interventions for PLHIV						

Interface Meeting- CSC tool for Malaria services delivery

Name of the facility:	**Level:**	**Parish:**
Sub-county:	**District:**	**Category of Clients:**

S.NO	Performance Criteria	Beneficiaries' (Men) SCORE	Beneficiaries' (Women) SCORE	Service Providers SCORE	Combined Score	Reason for score	Recommendation
1.0	**Malaria Vector Control**						
1.1	LLINs accessible and available, especially for pregnant women and						

S.NO	Performance Criteria	Beneficiaries' (Men) SCORE	Beneficiaries' (Women) SCORE	Service Providers SCORE	Combined Score	Reason for score	Recommendation
1.2	Household IRS Spraying done (For only areas where IRS is conducted)						
	Case Management						
1.3	Trained and skilled health workers in malaria diagnosis and treatment available						
1.4	Malaria case management SBCC materials available						
1.5	Quality of VHT services in relation to malaria Community Case Management						
1.6	ACTs (including tablets, rectal and injections) available at the health facility						

Interface Meeting-CSC tool for RMNCAH Services delivery

Name of facility:	**Level:**	**Parish:**
Sub-county:	**District:**	**Category of Clients:**

S.NO	PERFORMANCE CRITERIA	Beneficiaries' (Men) SCORE	Beneficiaries' (Women) SCORE	Service Providers SCORE	Combined Score	REASON FOR SCORE	RECOMMENDATION
1.0	**Adolescent health and nutrition**						
1.1	Adolescent sexual and reproductive health education and counselling services						
1.2	Individual nutrition counselling services at HIV care and treatment sites.						
1.3	Availability of therapeutic or supplementary food at the health facility						
2.0	**Family planning services**						
2.1	Quality of family planning counselling and information						
2.2	Postpartum/post abortion family planning counselling and services for women						
2.3	Male friendly services (paternal responsibility and men only services).						

2.4	Contraceptive use						
2.5	Management of STIs						
3.0	**Maternal Health**						
3.1	Pregnant women attending ANC sessions						
3.2	Institutional deliveries						
3.3	Cervical cancer routine screening and treatment services available						
3.4	Breast cancer routine screening and treatment services						
3.5	Availability and accessibility to post abortion care services						
4.0	**Child Health**						
4.1	Integrated Management of Childhood Illnesses services and commodities (ACTs, antibiotics, zinc, Vitamin A and ORT) for children under five						
4.2	Children under one year immunized with 3rd dose Pentavalent vaccine						
4.3	One-year old children immunized against measles						

Interface Meeting- CSC tool for Gender and Human rights

Name of the facility:		**Level:**				**Parish:**	
Sub-county:		**District:**				**Category of Clients:**	
S.NO	**PERFORMANCE CRITERIA**	**Beneficiaries' (Men) SCORE**	**Beneficiaries' (Women) SCORE**	**Service Providers SCORE**	**Combined Score**	**REASON FOR SCORE**	**RECOMMENDATION**
1.1	Availability of Integrated Strategies to prevent GBV and HIV						
1.2	Availability of interventions to address Harmful cultural practices						
2.0	**Human Rights**						
2.1	Existence of Criminalization of particular populations						
2.2	Stigma and discrimination in the education,						

2.3	community and justice sectors against people						
2.4	Violations of women's property and inheritance						
2.5	Lack of access to HIV prevention and treatment						

Community Scorecard Interface Meeting - Tool for KPs: Community Scorecard

Name of facility:		**Level:**				**Parish:**	
Sub-county:		**District:**				**Category of Clients: KPs**	
S.NO	**PERFORMANCE CRITERIA**	**Beneficiaries' – KPs SCORE**	**Beneficiaries- General Pop (Women & Men) SCORE**	**Service Providers SCORE**	**Combined Score**	**REASON FOR SCORE**	**RECOMMENDATION**
1.0	**HIV PREVENTION**						
1.1	Availability of Condom (Male and Female condoms)						
1.2	HIV Testing and Counselling services						
1.3	Existence of STI interventions and management for KPs and						
1.4	Availability and accessibility of PEP						
1.5	Availability and accessibility of PrEP						

1.6	Availability and access to condom compatible lubricants						
1.7	Availability of KP responsive health promotion IEC (interventions – specifically targeting KPs						
1.8	Willingness to utilize KP services if they are made available						
2.0	**CARE AND TREATMENT**						
2.1	Access to ART for Adults						
2.2	Availability of Viral load monitoring services						
3.0	**Enablers and barriers to accessing services**						
3.1	Unfriendly health workers and community in general						
3.3	Discrimination and marginalization						
4.0	Legal environment in relation to KPs						
4.1	Existence of criminalization of KPs						
4.2	Awareness of rights and the law						
4.3	Frequency of KPs encounters with Police						

4.4	Access to legal and other support services						
Name of the facility:		**Level:**				**Parish:**	
Sub-county:		**District:**				**Category of Clients: Key Populations**	
S.NO	**PERFORMANCE CRITERIA**	**Beneficiaries' – KPs SCORE**	**Beneficiaries- General Pop (Women & Men) SCORE**	**Service Providers SCORE**	**Combined Score**	**REASON FOR SCORE**	**RECOMMENDATION**
	TUBERCULOSIS						
1.0	Case notification and identification						
1.1	Availability of qualified staff to screen and diagnose TB.						
1.2	TB care and prevention integrated into other healthcare service delivery interventions						
1.3	Availability of TB screening and testing equipment						
1.4	Availability of facility - community linkages for TB						
1.5	Availability of IPT services among PLHIV to those without TB						

1.6	Availability of TB/HIV interventions for PLHIV						
	MALARIA						
1.0	**Malaria Vector Control**						
1.1	LLINs accessible and available especially for						
1.3	Malaria case management SBCC materials available						
1.4	Quality of VHT services in relation to malaria						
1.5	ACTs (including tablets, rectal and injections) available at Malaria case management SBCC materials available at the health facility						

Infrastructure

Theme	Indicator/Variable	Tick if available	Comments
Safe water	**Availability of good and safe water** a) Is there constant flowing clean water? b) Any cost involved		
Transportation	**Availability of transport** a) Find the type of transport available (motorcycle at HCIII, IV ambulance at HC IV and hospital) b) Is it always there? Functional?		
Housing for staff	**Adequate number of staff houses** a) Number? Adequacy? Condition in which there are in		
Shelter	**Adequate toilets, kitchen, and shelter** a) Number? Adequacy? Condition?		

Communication facilities	**Communication facilities** a) Use and functionality of Notice boards b) Suggestion box c) Telephone booth		
Consultation rooms	**Availability of consultation rooms** a) Presence of the room b) Privacy (are there window curtains, is the door closed during consultations, are there interruptions from other staff during consultations)		
Power supply	**Availability of power & type** a) Is there power? b) Is it solar/ hydro? c) Is it regular?		

Appendix VI: List of Health Facilities Assessed

Health Facilities Assessed during Community Scorecard			
Sub-region	**Districts**	**Selected Health Facility**	**Level**
East Central	Tororo	1. Mulanda	IV
		2. Molo	III
		3. Mudakor	III
		4. Paya	III
	Mbale,	5. Bufumbo	IV
		6. Bumadanda	III
		7. Bumasikye	III
		8. Busano	III
	Bukwo	9. Chesower	III
		10. Kapkoloswo	III
		11. Kortek	III
		12. Riwo	III
Greater North	Kole,	13. Aboke	IV
		14. Akalo	III
		15. Bala	III
		16. Amolydang	III
	Otuke,	17. Orum	IV
		18. Barjobi	III
		19. Olilim	III
		20. Okwongo	III
	Alebtong	21. Alebtong	IV
		22. Amugu	III
		23. Omoro	III
		24. Apala	III
	Dokolo	25. Dokolo	IV
		26. Agwatta	III

		27. Kangai	III
		28. Kwera	III
	Apac,	29. Akokoro	III
		30. Ibuje	III
	Amolatar,	31. Amolatar	IV
		32. Aputi	III
		33. Etam	III
	Amuru,	34. Atiak	IV
		35. Bibia	III
		36. Pawel	III
		37. Pogo	III
	Pader,	38. Pajule	IV
		39. Laguti	III
		40. Puranga	III
		41. Awere	III
	Lamwo	42. Padibe	IV
		43. Padibe West	III
		44. Palogo	III
		45. Palebek Ogili	III
South West	Rubirizi,	46. Rugazi	IV
		47. Katunguru	III
		48. Katerera	III
	Kisoro	49. Busanza	IV
		50. Nyarubuye	III
		51. Muramba	III
		52. Nyarusiza	III
	Ntoroko,	53. Karugutu	IV
		54. Ntoroko	III
		55. Rwebisengo	III
Mid-west	Hoima,	56. Kigorobya	IV
		57. Buhanuka	III

		58. Butema	III
		59. Karongo	III
	Bulisa,	60. Bulisa	IV
		61. Avogra	III
		62. Butiaba	III
		63. Biiso	III
	Masindi,	64. Bwijanga	IV
		65. Kimego	III
		66. Kyatiri	III
	Kagadi,	67. Kabamba	III
		68. Kiryanga	III
		69. Isunga	III
		70. Mpeefu B	III
Central	Kyankwanzi	71. Ntwetwe	IV
		72. Butemba	III
		73. Kikonda	III
		74. Kiyuni	III
	Nakaseke,	75. Semuto	IV
		76. Kikamulo	III
		77. Kapeeka	III
		78. Mifunya	III
	Nakasongola,	79. Nakasongola	IV
		80. Kalungi	III
		81. Nakitoma	III
		82. Nabiswera	III
	Kiboga,	83. Bukomero	IV
		84. Kambugu	III
		85. Lwamata	III
		86. Muwanga	III
	Luwero	87. Kalagala	IV

		88. Bamananika	III
		89. Katikamu	III
		90. Bukalasa	III
	Kalangala,	91. Kalagala	IV
		92. Mugoye	III
	Buikwe,	93. Kisubi	III
		94. Najjemba	III
		95. Wakisi	III
	Buvuma,	96. Bugaya	III
		97. Namatale	III
		98. Lukale	III
	Kayunga	99. Bbale	IV
		100. Nazigo	III
Health Facilities Assessed during Community Scorecard For KPs Health Services			
Sub-region	**Districts**	**Selected Health Facility**	**Level**
East Central	Busia	1. Busia	IV
		2. Lomino	III
		3. Majanji	III
		4. Bulumbi	III
Greater North	Lira	5. Lira Hospital	RR
		6. Ogur	IV
		7. Ober	III
		8. Abala	III
Mid-west	Kasese	9. Rukoki	IV
		10. St. Paul-Kasese	III
		11. Kasese Municipal Council	III
Central	Wakiso	12. Kasangati	IV
		13. Busawamanze	III
		14. Kasanje	III
		15. Namulonge	III